PROVINCIAL COURT OF NOVA SCOTIA
Citation: *R. v. The Brick Warehouse LP*, 2024 NSPC 26

Date: 20240410
Docket: 8532196
8532197
8532198
Registry: Halifax

Between:

His Majesty the King

v.

The Brick Warehouse LP

SENTENCING DECISION

Judge:	The Honourable Judge Elizabeth Buckle
Heard:	November 15, 2023, and January 18, 2024
Decision:	April 10, 2024
Charge:	s. 74(1) of the *Occupational Health and Safety Act* x 3
Counsel:	Alex Keaveny for the Crown Ron Pizzo for the Defendant

By the Court:

Introduction

[1] Following a trial, I found the Brick Warehouse LP (the Brick) guilty of three offences under the Nova Scotia *Occupational Health and Safety Act* (*OHSA*): two counts of failing to ensure that their policies were implemented; and, one count of failing to ensure that a toilet facility was adequately illuminated.

[2] Investigators laid the charges following an investigation into the death of Martin David, an employee of the Brick.

[3] I must now sentence the Brick for these offences.

[4] Under the *OHSA*, if any of the offences "resulted in" Mr. David's death, the maximum penalty for that offence is a fine of $500,000 rather than $250,000. Following a hearing on that issue, I concluded that I was not persuaded beyond a reasonable doubt that any of the offences had "resulted in" Mr. David's death. Therefore, the maximum penalty for each offence is $250,000.

[5] The Crown seeks a fine for each offence of $62,500 for a total fine of $187,500 with statutory victim fine surcharge of $28,125. The Crown also seeks a creative sentencing order that would require the Brick to make four educational presentations.

[6] The Defence argues that two of the offences should be stayed due to the application of the principles in *Kienapple* with the result that the Brick would be sentenced for only one offence. The Defence does not disagree with the creative sentencing order suggested by the Crown but submits that the global financial penalty should be in the range of $20,000 to $35,000.

[7] I will first provide my reasons for concluding that the offences did not "result in" Mr. David's death. I will then decide whether any of the charges should be stayed. Finally, I will determine the appropriate penalty.

Issue 1: The Offences Did Not "Result In" Mr. David's Death

<u>General Principles</u>

[8] When the Defence disputes an aggravating fact in a sentencing hearing, the Crown must prove it beyond a reasonable doubt by the Crown (*Criminal Code* s. 724(3)(e) which applies by operation of the *Summary Proceedings Act, S.N.S. 1989, c. 450 as amended*; *R. v. Gardiner*, [1982] 2 S.C.R. 368, pp. 414-415; and *R. v. Phinn*, 2015 NSCA 27, paras. 46-50).

[9] Proof beyond a reasonable doubt is a high standard. It is more than suspicion or probability. It is not proof to an absolute certainty but falls much closer to absolute certainty than to proof on a balance of probabilities. It is not proof beyond any doubt, nor is it an imaginary or frivolous doubt. It is based on reason and common sense, and not on sympathy or prejudice (*R. v. Starr,* [2000] S.C.J. No. 40; *R. v. Lifchus*, [1997] 3 S.C.R. 320.).

Arguments and Legal Principles

[10] The Crown argues that it has proven that two of the offences "resulted in" the death of Mr. David: the failure to ensure that the toilet facility was adequately illuminated; and the failure to ensure that the Lighting Policy was implemented.

[11] The Defence disagrees.

[12] To decide whether the Crown has met its burden, I will first have to determine what the test for causation is in this context – a regulatory sentencing where a threshold causation requirement results in exposure to a higher penalty. I must then assess whether I am satisfied beyond a reasonable doubt that the evidence meets the test.

What is the Standard for Causation in this Context?

[13] Both the Crown and Defence have referred to my discussion of causation in the case of *R. v. Hoyeck*, 2020 NSPC 24 - another sentencing under the Nova Scotia *OHSA* where there was a death. While the sentence I imposed was varied on appeal, my comments on causation were not discussed (*R. v. Hoyeck*, 2021 NSSC 178).

[14] Mr. Hoyeck had been acquitted of criminal negligence causing death because the Crown had not proven causation. He then pleaded guilty to offences under the *OHSA.* At sentencing, the Defence argued that I was bound by that conclusion from the criminal trial. I disagreed. I concluded that the test for factual

causation would be the same regardless of the proceeding but that the test for legal causation could be different in the sentencing context:

> [47] In a legal setting, causation has two aspects: factual causation; and, legal causation. Where there is a death, the inquiry into factual causation asks how the victim came to his or her death, in a medical, mechanical, or physical sense, and whether the accused contributed to that result (*R. v. Nette*, 2001 SCC 78, at para. 44). That inquiry will not generally be impacted by the type of proceeding. The inquiry into legal causation asks whether the accused should be held legally responsible for that death (*Nette*, at para. 45). It narrows the circumstances where factual causation has been proven to those which are sufficiently connected to a harm to warrant legal responsibility. It is "based on concepts of moral responsibility and is not a mechanical or mathematical exercise" (*Nette*, at para. 83; *R. v. Maybin*, 2012 SCC 24, at para. 16). As a result, the concept of legal causation may be impacted by the type of proceeding; it can vary depending on the legal provision being interpreted and the legal context of the analysis (*Nette*, at para. 45).
>
> [48] Mr. Hoyeck was acquitted in the criminal trial because the applicable legal test for causation was not met. The test in that context, where guilt or innocence of a criminal offence was at stake, was whether Mr. Hoyeck's actions or his inaction where he had a duty to act was a significant contributing cause of Mr. Kempton's death. The Court concluded that the Crown had not met that test to the criminal standard of proof beyond a reasonable doubt.
>
> [49] That does not necessarily determine causation in the present context, a regulatory sentencing hearing.
>
> [50] In assessing factual causation, the test is generally a "but for" test – "but for" the conduct of the accused, would the result have happened? (*Nette*, at para. 45; and, *Maybin*, at para. 4). It is not limited to the direct and immediate cause, nor is it limited to the most significant cause (*Maybin*, at para. 20). There may be a number of contributing causes, but if the conduct of the accused contributed in a non-trivial way, factual causation is established.

[15] So, to determine whether the Brick's offences caused Mr. David's death in a factual sense, I have to ask whether the Crown has proven beyond a reasonable doubt that 'but for' the Brick's failures, Mr. David would have died. If the Crown proves beyond a reasonable doubt that the Brick's action or inaction contributed to the death in a non-trivial way, factual causation has been proven. The Crown does not have to prove that the Brick's failure was a direct or immediate cause, just that it played a non-trivial role.

[16] The second part of causation is legal causation. As I stated in *Hoyeck* at para. 52:

> …the test for legal causation in the regulatory sentencing context is not the same as in the criminal trial context. Specifically, it does not require that the conduct be a significant or substantial cause in order for the fatality to be considered in the proportionality analysis. [Emphasis added.]

[17] That conclusion related to the legal causation standard that would allow consideration of death when applying the purposes, principles, and objectives of sentencing. It did not address the legal causation standard that would trigger the application of s. 74(1B).

[18] The analysis that led to that conclusion was rooted in consideration of the principles and objectives of sentencing, including the principle that a sentence must be proportionate and take into account all aggravating factors. The proportionality analysis requires a court to determine the gravity of the offence, assess moral blameworthiness on a spectrum of culpability, and apportion responsibility for the harm. My reasoning in *Hoyeck* was applied by the New Brunswick Provincial Court in *R. v. Schenkels Farm Inc.,* 2021 NBPC 15, but that was also for purpose of the proportionality analysis as the New Brunswick statute does not have different maximum penalties for fatality offences.

[19] Section 74(1B) does include a threshold causation requirement which, if met, results in a higher maximum penalty which can also result in a higher penalty for an offender.

[20] The legal causation requirement in this context may very well be different than what is required to simply consider a fatality in the proportionality analysis or as an aggravating factor. It may be that the criminal standard for legal causation applies in this context such that the Crown would have to prove the conduct was a significant or substantial cause of the fatality. Some support for that position can be found in cases such as *Gardiner* and *Nette.* In *Gardiner*, the Supreme Court concluded that the criminal standard of proof would apply in a sentencing proceeding where the Crown wanted to rely on a disputed fact to justify an increased penalty. In *Nette* and *Maybin,* the Supreme Court linked the standard for legal causation to context. It is arguable that where the context is a statutory causation requirement that exposes an offender to a significantly higher penalty, the criminal standard of legal causation is required.

[21] Here the Crown argues that the absence or inadequacy of lighting contributed to Mr. David's death both by making it more likely that he fell and less likely that he could react to falling and lessen the impact of the fall(s).

Relevant Facts from Trial

[22] My detailed factual findings are contained in my trial decision. The only additional evidence at this hearing came from Dr. Erik Mont who had also testified at trial. He is a medical examiner who is also licenced to practice medicine in Nova Scotia. I qualified him to give expert opinion evidence on the cause and manner of death, and the diagnosis, prognosis, and treatment of injuries.

[23] At trial, I concluded that Mr. David sustained the fatal injury at work when he fell and hit his head in the washroom or in the hallway leading to the washroom. At the time, the washroom was in total darkness, but there was some illumination in the hallway.

[24] About five minutes before the fatal fall, Mr. David had another fall in the warehouse which was captured on video. He did not hit his head during that fall but appeared to be suffering some adverse effects. He said that he was feeling anxious and sat down for a few minutes. When he got up he appeared 'shaken' or unsteady on his feet. He was, however, able to perform physical tasks and walked to the washroom, approximately 150 to 200 feet away. During that walk, he did not exhibit any issues with balance, did not pause or stagger, and was steady on his feet.

[25] Mr. David was alone and not on video for 90 seconds before he was found on the floor of an employee washroom. During that time, he walked approximately 60 feet along a hallway and entered the washroom. We don't know exactly what happened during that period.

[26] When he was found, he was face down on the washroom floor with his head on his hands. His feet were toward the urinal and his head away from it. The zipper on his pants was down and his penis exposed. His cognition and physical mobility were both impaired. He was not responding normally to questions and had variable levels of consciousness. He was able to crawl to a toilet, where he vomited a few times, and to a sink, where he pulled himself up to splash water on his face but did not stand. His breathing was heavy. He was taken to hospital where he died two days later.

[27] Mr. David had a fracture on the back of his skull, an injury to the area above and around his right eye, and bleeding between his skull and brain. The injury on the back of his head caused his death. That injury was caused by a direct impact, probably from his head striking a stationary broad surface. The injury above his right eye was caused by a separate impact.

[28] The evidence does not allow me to determine whether the two injuries were caused during a single fall or in what order they occurred. They may have been part of the same fall with Mr. David striking two objects or could have been two separate injuries with him falling, getting up or trying to get up, and then falling again.

[29] Dr. Mont testified that the injury on the back of Mr. David's head would be commonly seen if a person fell backward from standing and struck their head on the ground or floor.

[30] He testified that he would not expect to see this type of injury from a glancing blow or if someone merely fell against a wall. He acknowledged that it could be caused by someone fainting and falling backward, that the injury to the eye could have occurred first or second, and that the fall, or one of the falls, could have been in the hallway or the washroom.

[31] Dr. Mont could not provide any medical opinion as to whether the absence of lighting caused or contributed to Mr. David's fall or injury.

[32] Dr. Mont did not find any underlying medical condition that could have contributed to the fall. He could not say whether the earlier warehouse fall impacted him physiologically beyond what can be observed on the video or described by witnesses.

[33] I have concluded that Mr. David probably sustained the fatal injury while he was in the washroom and probably while he was standing at the urinal, either just before or just after urinating. I say that because of the position he was in when he was found and because his zipper was down with his penis exposed when he was found. It is unlikely that he would have had his zipper down before entering the washroom or before approaching the urinal, and unlikely that, if he urinated, he would have left his zipper open for long after.

[34] There is no direct evidence of any obstructions on the floor that Mr. David could have tripped over or any liquid that he might have slipped on.

Has Causation Been Proven?

[35] The Crown can prove causation without direct evidence and without expert opinion evidence. It can be proven through direct or circumstantial evidence or a combination of both. However, it must be proven beyond a reasonable doubt.

[36] To be satisfied by circumstantial evidence that it has been proven beyond a reasonable doubt, I must be satisfied that the inference the Crown seeks to rely upon is the only reasonable inference to be drawn from the evidence (*R. v. Griffen*, [2009] S.C.J. No. 28, para. 34). There is no burden on the Defence to persuade me that there are other more reasonable or even equally reasonable inferences that can be drawn**.** Further, a reasonable doubt may be logically based on a lack of evidence (*R. v. Vilaroman*, 2016 SCC 33**,** para. 36). I must assess "whether the circumstantial evidence, viewed logically and in light of human experience, is reasonably capable of supporting an inference other than guilt" (*Vilaroman*, at para. 38).

[37] In drawing inferences, I must be careful not to confuse a reasonable inference with speculation. A reasonable inference is one that is based in common sense, logic, or human experience but must be grounded in or flow from the proven facts (e.g. *R. v. Pastro*, 2021 BCCA 149). In Watt's Manual of Criminal Evidence (2023) it is described as (para. 12.01):

> An *inference* is a deduction of fact that may logically and reasonably be drawn from another fact or group of facts found or otherwise established in the proceedings. It is a conclusion that *may*, not must be drawn in the circumstances. [Emphasis in original.]

[38] Speculation occurs where an inference is not based on proven facts or where it cannot be reasonably and logically drawn from the proven facts.

[39] I have no direct evidence of what caused Mr. David to fall. I can make inferences based on the evidence. I agree with the Crown that the most likely scenario is that Mr. David was shaken or 'woozy' from his earlier fall in the warehouse, that he went to the washroom to urinate, and then fell and struck his head, perhaps on the urinal and the floor.

[40] I accept that Mr. David probably sustained the fatal injury while in the washroom and that the washroom was in darkness. To prove factual causation, the Crown must prove beyond a reasonable doubt that the darkness contributed to Mr. David's death in a non-trivial way, by either contributing to the fall or the

consequences of the fall. The Crown does not have to prove that the darkness was the direct or immediate cause, that it was the only factor, or even that it was the most significant factor.

[41] I am not persuaded beyond a reasonable doubt that the darkness contributed, in a non-trivial way, to the fall or its fatal consequences. Framed another way, I am not satisfied beyond a reasonable doubt that 'but for' the failure to provide lighting, Mr. David would not have fallen or that he would have survived the fall. I say that for the following reasons.

[42] The Crown argued that common sense should tell me that darkness played a non-trivial role in Mr. David's death because it increased the likelihood of a fall and impacted his ability to react, making the consequences of the fall more likely to be fatal. An aspect of the Crown's argument is that the room was dark and there is no medical or other explanation for why he fell. Therefore, darkness must have contributed to the fall.

[43] I can use common sense and my own life experience to help make inferences from the evidence. However, I must exercise caution.

[44] I can also take judicial notice of facts that are either: 1) so notorious or generally accepted as not to be the subject of debate among reasonable persons; or 2) capable of an immediate and accurate demonstration by resort to readily accessible sources of indisputable accuracy (*R. v. Find*, 2001 SCC 32, para. 48).

[45] First, I will address the Crown's argument that the darkness played a non-trivial role in the fall(s). Common sense and my own life experience tells me that I can stand and even move around in a dark room without falling. Even accepting that Mr. David was dizzy or woozy from his earlier fall, I have no evidence that darkness would exacerbate the effects of that condition. That is not something that I can conclude based on common sense, my life experience, or judicial notice. That kind of physiological conclusion requires expert evidence.

[46] The Crown submits that the darkness makes it more difficult to navigate space and has identified the many and obvious risks of the absence of lighting, especially in a washroom. I accept this argument. If someone is moving around in a dark room there is an increased risk of slipping, tripping, or banging into things. If there is water on the floor, a common situation in a washroom, it can't be seen and there is an increased risk of slipping. However, I have no evidence that Mr. David did any of these things. There is no evidence that he was moving when he

fell, no evidence that there was anything on the floor that he could have fallen over, and no evidence that there was water on the floor that he slipped on. The Crown has not proven that these risks played a part in causation.

[47] These may be reasonable inferences. However, an alternative reasonable inference is that Mr. David fainted. This possibility was acknowledged by Dr. Mont. I infer from his evidence that the absence of a preexisting medical condition does not rule out the reasonable possibility that he fainted.

[48] The Crown also submits that the darkness would have prevented Mr. David from stopping himself from falling because he would not have been able to see the wall. I accept that a natural inclination if someone is feeling dizzy or unwell would be to reach for the wall. If you can't see the wall, you may misjudge and fall. A difficulty with this submission is that I don't have evidence that Mr. David had any warning before he fell. If he did feel dizzy or unwell, another natural inclination would be to simply sit down and it appears he did not do that. Based on the evidence, it is equally plausible that he simply fainted without the opportunity to reach out to stop his fall.

[49] I will now address the Crown's argument that the darkness played a nontrivial role in the consequences of the fall. The Crown argues that the darkness would interfere with depth perception and impede a person's ability to break their fall because they wouldn't know where the floor was. Again, I accept that a natural inclination when one is falling would be to put their hands down to break their fall. Common sense and my life experience tell me that the darkness would not interfere with the ability to do that. Mr. David was standing on the floor. He knew where the floor was. If he knew he knew he was falling, he could have put his hands out to try to stop the fall.

[50] I accept that it is possible that the darkness contributed to Mr. David's death. It is possible that he bumped into a wall or slipped on water. It is possible that he was experiencing "wooziness" from his earlier fall that was exacerbated by darkness. It is possible that he reached for a wall and due to the darkness, misjudged where it was and fell and hit his head. However, those possibilities do not amount to proof beyond a reasonable doubt. There are other reasonable inferences from the facts. It is reasonably possible that he fainted, whether due to the physiological impact of the earlier fall or something else, and then fell backward without any opportunity to break his fall.

[51] Because the Crown has not proven factual causation it is unnecessary for me to decide whether legal causation has been proven.

Issue 2: The *Kienapple* Principle Does Not Apply to Any of the Offences

[52] The Brick was found guilty of counts one, three, and four: failing to ensure their accident investigation policy was implemented; failing to ensure that a toilet facility was adequately illuminated; and failing to ensure their lighting police was implemented.

[53] The Defence submits that two of the three charges should be stayed due to the application of the principles from *Kienapple v. The Queen*, [1974] S.C.J. No. 76. Alternatively, the Defence submits that one of the two charges relating to lighting should be stayed. The Crown disagrees.

[54] The *Kienapple* principle does not prohibit multiple convictions arising from the same transaction. It "is designed to prevent multiple convictions arising from the same 'matter', 'cause' or 'delict'" (*R. v. Deslisle,* 2003 BCCA 196, para. 12). It applies where charges have a factual and legal nexus (*Wigman v. The Queen* (1987), 33 C.C.C. (3d) 97, p. 103; and *R. v. Prince,* [1986] 2 S.C.R. 480, paras. 17-39).

[55] As the Supreme Court said in *Prince*, at para. 24:

> In most cases … the factual nexus requirement will be satisfied by an affirmative answer to the question: Does the same act of the accused ground each of the charges?

[56] There are exceptions, so, in each case the court will have to look at the circumstances to determine whether the factual connection between the charges is sufficient to justify the application of the rule. Relevant factors can include the remoteness or proximity of the events in time and place, the presence or absence of relevant intervening events, and whether the accused's actions were related to each other by a common objective (*Prince,* para. 20).

[57] I am unable to see how there is a factual nexus between count two (the offence relating to failing to implement the accident investigation policy) and counts three and four (the failures relating to lighting).

[58] The act that grounded the conviction for count two was the failure to ensure that the Brick's accident investigation policy was followed. The act that grounded

count three was the failure to have adequate illumination in the washroom as required by the *Occupational Safety General Regulations* (*GSR*). The act that grounded count four was the failure was to take steps to ensure the Brick's lighting policy was followed.

[59] The act that grounded count two is not the same as the act that grounded counts three and four so there is not a sufficient factual nexus to trigger the *Kienapple* principle.

[60] I am satisfied there is a factual nexus between counts three and four (the two lighting offences). I recognize that the failures that grounded each count are not identical. The failure that grounds count four is factually broader than the failure that grounds count three. However, given the reasons for conviction, there is sufficient factual overlap. The failure to have adequate illumination in the toilet facility is in some respects factually subsumed in the broader charge and there is no factor that detracts from the factual connection between the charges.

[61] However, a factual nexus alone is not sufficient to trigger the *Kienapple* principle (*Prince*, paras. 21-39). A single act can give rise to different 'matters', causes or 'delicts' and sustain multiple convictions. For example, a single act of hunting can result in convictions for both hunting out of season and hunting at night (*McKinney v. The Queen*, [1980] 1 S.C.R. 401, affirming (1979), 46 C.C.C. (2d) 566 (MBCA). As the Court said in *Prince*, "… if an accused is guilty of several wrongs, there is no injustice in his or her record conforming to that reality" (*Prince*, para. 24).

[62] Offences will not meet the legal nexus requirement if they have any "additional and distinguishing element that goes to guilt" (*Prince*, paras. 27-39). However, even where there are no distinguishing elements, other factors can defeat the legal nexus requirement (*Prince*, paras. 27-39; *R. v. R.K.* (2005) 198 C.C.C. (3d) 232 (ONCA), para. 38). In *Prince*, the Supreme Court said that the *Kienapple* principle will not apply where offences are aimed at different "evils" or "wrongs" and/or different societal interests (paras. 23-24 & 39). The Court provided the example of a conviction for a substantive offence and a breach of probation for failure to keep the peace and be of good behaviour for the same conduct that grounded the substantive offence. The breach offence is designed to protect the societal interest in effective operation of the criminal justice system which is different than the societal interest protected by a substantive offence such as assault (*R. v. Pinkerton* (1979), 46 C.C.C. (2d) (BCCA);

[63] As Justice Doherty said in *R.K.* at para. 39:

> … the crucial distinction for the purposes of the application of Kienapple rule is between different wrongs and the same wrong committed in different ways. If the offences target different societal interests, different victims, or prohibit different consequences, it cannot be said that the distinctions between the offences amount to nothing more than a different way of committing the same wrong.

[64] It is arguable whether there are distinguishing elements between counts three and four. However, the focus of the Crown's argument is that the *Kienapple* principle does not apply because the offences are aimed at different societal interests.

[65] I agree with the Crown. The offence of failing to ensure a policy is implemented is aimed at a different 'evil' or 'wrong' than the offence of failing to comply with a specific *OHSA* requirement. Both contribute to the principal purpose of the *OHSA* which is to protect workers (*R. v. Meridian Construction Inc.*, 2005 NSPC 40, para. 13).

[66] However, the purpose of requiring employers to implement policies is different than the purpose of having specific substantive expectations. Occupational health and safety (OHS) policies set standards, inform employees and managers of those standards, and hold management accountable to those standards. Having a policy does not accomplish these goals and does not advance worker safety if the policy is not implemented, meaning the employer does not effectively inform and educate employees and managers of what it says and how to follow it, and does not take steps to ensure it is being followed. The 'wrong' that is addressed by the offence in count four is the risk that employers will superficially address safety issues by introducing policies but will not inform, police, and enforce the standards they contain. In contrast, count three is narrower and focused on a specific safety hazard.

[67] In summary, these offences are not simply different ways of committing the same wrong; they relate to different 'wrongs'. Therefore, they do not meet the test for application of the *Kienapple* principle.

[68] However, there is significant overlap between counts three and four. The primary culpable conduct for both offences is the failure to illuminate the washroom. The sentences here will be fines which cannot be concurrent (*R. v. Ward*, 1980, ONCA, para. 9). It is important to ensure a sentence that is ultimately

fair. I recognize that by convicting the Brick for both offences and imposing 'consecutive' sentences, there is a risk of punishing them twice for the same primary culpable conduct. That will be addressed and avoided through proper application of proportionality and the principles of totality and restraint.

Issue 3: What is the Appropriate Sentence?

[69] I am sentencing the Brick for three offences under s. 74(1) of the *OHSA*. They failed to ensure their lighting policy and accident investigation policies were implemented contrary to s. 7(1) of the *GSR* and failed to ensure that the toilet facility was adequately illuminated contrary to s. 19(6) of the *GSR*.

[70] The maximum penalty for each of these offences is a fine of $250,000. In addition, I can make an order that engages more creative, restorative, sentencing options, including requiring the Brick to participate in public education (*OHSA*, s. 75(1)).

[71] The Crown seeks a fine for each offence of $62,500, for a total fine of $187,500 (plus the mandatory $28,125 victim fine surcharge). The Crown also seeks an order that would require the Brick to make four educational presentations.

[72] The Defence does not disagree with the creative sentencing order suggested by the Crown but submits that the global financial penalty should be in the range of $20,000 to $35,000.

Circumstances of the Offence

[73] In addition to the circumstances outlined above there are additional facts that are relevant to sentencing.

[74] During the Covid pandemic, the Brick decided to change the automated lighting schedule in their retail outlet and warehouse to reflect Covid-related changes in their business hours. Warehouse employees came in earlier than retail and office employees so the lights in the warehouse were set to come on earlier. However, the warehouse employees and delivery drivers used a washroom in the office area of the building. Prior to making the change to the lighting schedule, no one considered that the warehouse and delivery drivers used that washroom and no one checked to see if the lighting change would affect the washroom. It did.

[75] For approximately two months before Mr. David's death, there were no lights in the washroom for a little over an hour each morning when warehouse employees and drivers would be expected to be in the building. There were also no windows in the washroom such that it was in darkness.

[76] Employees used the washroom during that time and typically used their phones as a flashlight. There is no evidence that the warehouse manager or any employee reported the situation to a manager.

[77] There was a manual switch on an electrical box in the warehouse that could have turned on the washroom lights. However, that switch was 150 to 200 feet from the washroom, there was no evidence that employees were told it was there or that they were allowed to use it, and it was not labeled.

[78] During this time, the Brick had a safety program that included:

- OHS policies that were available to employees and managers (Ex. 5);
- mandatory online health and safety orientation for employees (Ex. 5 and 11));
- mandatory monthly online learning modules for employees (eg. Ex. 12);
- regular safety talks (Ex. 5and 18); and
- a joint OHS committee that produced and shared Minutes of its meetings, did monthly safety checks of the store, and daily 'slips, trips and falls' checks (Ex. 16).

The Brick had a system to ensure that all employees completed the required orientation and monthly safety modules. The Brick also appears to have responded to all issues identified in the monthly and daily safety checks.

[79] However, the problem with the lights was not prevented or caught. The managers who made the decision to change the lighting schedule did do a workplace hazard assessment and safety checks of the premises. However, these assessments and safety checks were apparently not conducted during the hour each day when it was a problem.

[80] The Brick had an adequate lighting policy and an adequate accident investigation policy. However, they did not implement those policies. Both were in the OHS binder and employees knew there were policies in an OHS binder. However, some employees who testified did not know the location of the binder

and none had a proper understanding of either policy. The Brick did not take steps to ensure that the policies were followed. They did not provide proper training and education on the policies and failed to conduct checks to ensure understanding and compliance.

[81] Orientation modules that all employees took only vaguely referred to lighting. They did alert employees and managers that they have certain obligations for accident reporting and investigation. However, they provide little detail about how to do an accident investigation. There is no evidence that any of the monthly modules or safety talks dealt with lighting or accident reporting or investigation.

[82] Significantly, for the accident investigation policy, the two managers who would have had important reporting and investigation obligations under the policy were not entirely familiar with their obligations. The manager on scene on the day Mr. David fell didn't recognize this policy and testified that he had not received any detailed training on it. He had an incomplete understanding of his obligations. The store manager who was on vacation on the day Mr. David fell was familiar with the policy. However, she also did not describe a complete understanding of the investigative obligations set out in the policy.

[83] There are other relevant circumstances that did not contribute directly to the convictions but are relevant to sentencing.

[84] Neither of the Brick's policies incorporated language from the Nova Scotia *OHSA* or Regulations. Indeed, the Orientation Module relating to accident investigation sets out a reporting obligation that is inconsistent with the *OHSA* and the accident investigation policy is also inconsistent with the Nova Scotia *OHSA*. It appears that policy was drafted to comply with legislation in Ontario.

[85] Mr. David was found on the floor of the washroom and was taken to the hospital. Despite that, no one from the Brick tried to contact him or his family until the next afternoon, more than 30 hours after he was found. At that time a supervisor at the Brick texted Mr. David. Regardless of whether they believed his condition was the result of an accident or illness, they knew his condition was serious. He was vomiting, had periods of lapsed consciousness, difficulty speaking, and exhibited an altered mental state. They had a moral obligation to try to contact him to see if he was ok. Given what they knew about his condition, they should also have known that he might not be able to contact his family himself and should have notified his family of what was happening.

[86] The consequences of that failure were significant. Mr. David did not come home on the night of June 9th and his family did not know his whereabouts. It was not until the next day when the hospital notified the family that they learned what had happened. If the Brick had notified Mr. David's family when he was taken to hospital it is possible they could have comforted him and said goodbye.

[87] The impact of this case on Mr. David's family and community is greater because Mr. David was African Nova Scotian. His mother, Laverne David, described her feelings that her family was treated differently because of their race and her fear that they would not receive justice for the same reason. There is no evidence that the fact that Mr. David was African Nova Scotian contributed to the Brick's failure to call him or his family or that Mr. David's race had any impact on the way the case was investigated or prosecuted. However, given the well-documented experiences of African Nova Scotians, Mrs. David's perception is not unreasonable.

[88] My life experience allows me only a small window into how Mr. David's family and other African Nova Scotians or members of marginalized communities would be impacted but Mrs. David described it eloquently in her victim impact statement.

Victim Impact Statements

[89] At the sentencing hearing, Dr. Kesa Munroe-Anderson read victim impact statements from six of Mr. David's family members: his mother, LaVerne David; his father, Marty David; his sister, Shaelene Himmelman; his spouse, Laura Jordan; and his aunts, Fay Williams and Norma Marsman. Many of these also speak about the impact of his death on his children.

[90] By reflecting on their pain, recording it, and exposing it publicly, these victims demonstrated a great deal of courage. Their willingness to do this is a testament to their feelings about Mr. David. Their words matter to this process and have helped me tremendously in my task.

[91] Each of these people knew Mr. David in a different way, experienced his loss in a different way, and provided the court with different insights into his personality. There are consistent themes of sorrow and regret: they did not have the opportunity to say goodbye to him; he will not be present for important events in their lives and the lives of his children and grandchildren; his younger children and grandchildren will not know him except through pictures and stories; and he

contributed to their lives in immeasurable ways. They all describe how impacted they were by how they found out about the incident and the Brick's failure to notify them. His spouse and parents describe the worry they felt when he didn't come home from work and their sorrow that they weren't with him in the hours before he died.

[92] Mr. David had four sons and grandchildren. He was an active and engaged father. He loved spending time with his children - he played with them and taught them important values. He was dedicated to his extended family and community. He was a long-time volunteer firefighter who would have been ready to help with the historic forest fires last summer. He also wrote poetry and took beautiful photographs. He loved driving, especially the firetruck. He loved MMA, both as a fan and a participant. He worked hard to provide for his family, working long hours and not missing any time. He was also interested in his heritage and in history and politics.

[93] His death has had psychological and emotional impacts on his entire family. For his spouse and younger children, there have also been economic impacts.

[94] Mr. David's mother noted that her son's generosity has extended beyond his death. Mr. David was an organ donor and five of his organs have helped others live longer or better lives. Remarkably, she also expressed forgiveness for the Brick.

Circumstances of the Brick

[95] The Brick is a wholly owned subsidiary of Leon's Furniture Ltd. As such, it is part of Canada's largest network of home furniture and appliance stores. Leon's has 204 corporate stores and 102 franchise stores and has total assets of $2 billion. The Brick operates on its own and is independent of the other subsidiaries.

[96] The Crown has not alleged any prior record for the Brick.

Comments on Behalf of the Brick

[97] Pursuant to s. 726, at the conclusion of the sentencing hearing, Mr. Greg Nakonechny, vice-president and legal and corporate secretary for the Brick, was given the opportunity to speak. He said that this incident has been taken seriously by the Brick and that they have made efforts to respond to it. He also apologized

to Mr. David's family and expressed personal understanding and sorrow for the impacts that this has had on them.

Sentencing Principles

[98] The general purpose, objectives, and principles of sentencing are set out in ss. 718 to 718.21 of the *Criminal Code*. These principles apply to sentencing in the provincial *OHSA* context (*Summary Proceedings Act,* s. 7).

[99] Other courts have provided helpful summaries for how to apply these principles in the OHS context (*Regina v. Cotton Felts Ltd.* (1982), 2 CCC (3d) 287; *R. v. General Scrap Iron and Metals Ltd.*, 2003 ABQB 22; *Meridian*; *Nova Scotia (Department of Environment and Labour) v. Nova Scotia Power, Inc.*, 2008 NSPC 72; and, *R. v. R.D. Longard Services Ltd.*, 2015 NSPC 35).

[100] In *Nova Scotia Power*, para. 27, Derrick, P.C.J. (as she then was) adopted the comments of Norman A. Keith from his text, "*Canadian Health and Safety Law: A Comprehensive Guide to Statutes, Policies and Case Law*" (Canada Law Book: 2008):

> There are three primary objectives of sentencing for a violation of the applicable health and safety legislation. First, there is the deterrence aspect of the sentencing process, both specific to the convicted party and generally for the community. Secondly, there is the retribution aspect of the sentencing process, indicating the moral wrong and the need to reinforce the value or standard that was violated. Thirdly, there is the rehabilitation-reform aspect of the sentencing process for the convicted party to be assisted in not repeating the offence.

[101] Justice Derrick went on to discuss other general principles:

> **29** The *Cotton Felts* decision accorded deterrence in the occupational health and safety context a broad meaning encompassing an emphasis on community denunciation and stigmatization of an act with the result being a moral or educative effect that conditions the attitude of the public. In approving this model of deterrence taken from *R. v. Roussy, [1977] O.J. No. 1208 (Ont. C.A.),* Blair, J.A. in *Cotton Felts* held that deterrence with an educative dimension is "particularly applicable to public welfare offences where it is essential for the proper functioning of our society for citizens at large to expect that basic rules are established and enforced to protect the physical, economic and social welfare of the public." (*paragraph 23*)
>
> **30** A sentence for an occupational health and safety infraction must communicate a message that emphasizes the essential responsibility of ensuring "corporate good conduct and [enhancing] the well being of the public." *(R. v. General Scrap Iron and Metals Ltd., [2003] A.J. No. 13 (Alta. Q.B.) paragraphs 28-30)* Watson, J. in *General*

> *Scrap Iron* concluded that sentencing corporations for regulatory offences should be approached with the following in mind:
>
> (1) the conduct, circumstances and consequences of the offence;
>
> (2) the terms and aims of the relevant legislation;
>
> (3) the participation, character and attitude of the corporation offender. (*General Scrap Iron, paragraph 35*)

[102] In addition to this sentencing framework, s. 718.21 of the *Criminal Code* sets out additional factors that must be considered when sentencing organizations for committing offences. Those that are potentially engaged here include the following:

> (a) any advantage realized by the organization as a result of the offence;
>
> (b) the … duration … of the offence;
>
> (d) the impact that the sentence would have on the economic viability of the organization and the continued employment of its employees;
>
> (e) the cost to public authorities of the investigation and prosecution of the offence; and
>
> (j) any measures that the organization has taken to reduce the likelihood of it committing a subsequent offence.

[103] To determine a fit and proper sentence, I must apply this legal framework to the specific circumstances of this offence and this offender.

Application of Principles

[104] The fundamental purpose of sentencing is to protect the public and to contribute to respect for the law and the maintenance of a safe society (*Code* s. 718).

Proportionality

[105] The fundamental principle of sentencing is proportionality (*Code,* s. 718.1).

[106] Proportionality requires that a sentence "reflect the gravity of the offence, the offender's degree of responsibility and the unique circumstances of each case" (*Criminal Code,* s. 718.1; *R. v. Parranto*, 2021 SCC 46, para. 12). It requires that a

sentence not be more severe than what is fair and appropriate but severe enough to condemn the offender's actions and to hold them responsible for what they have done (*R. v. LaCasse*, 2015 SCC 64, para. 12; *R. v. Nasogaluak*, 2010 SCC 6, para. 42).

[107] Assessing proportionality requires me to consider the gravity of the offence. That includes both the objective gravity of the offence and the subjective gravity of the offender's specific offending behaviour (*R. v. Friesen*, 2020 SCC 9, para. 96; *R. v. L.M.*, 2008 SCC 31, paras. 24 - 25).

[108] Dealing first with the objective gravity of the offences. There is no doubt that violations of *OHS* legislation are generally viewed as serious offences. As Judge Tufts said in *Meridian* at para. 13:

> … The workplace is an inherently dangerous environment. … Workers have very little power or leverage individually to control the safety measures which are necessary to protect them and minimize their risk of injury. They can only collectively bargain or rely on the legislative scheme such as the Occupational Health and Safety Act to protect them. The Occupational Health and Safety Act has as its' principle [sic] purpose, in my opinion, clearly, the protection of workers. …

[109] The relative objective gravity of an offence is informed by the maximum sentence set by Parliament (see *Friesen*, para. 96). The maximum penalty for each of these offences is $250,000. That is a high fine and signals the Legislature's intent that violations of the *OHSA* be treated seriously. However, that maximum is half what would apply where an offence is proven to cause a death.

[110] A violation of s. 74(1) of the *OHSA* captures a wide range of behaviour. That is narrowed somewhat by the particularization of the offences and I have to place the Brick's conduct and moral culpability on the continuum of behaviour that could constitute each of these offences.

[111] The Brick had a relatively comprehensive safety program. However, the problem with the lights was not prevented and not caught. The Brick changed the lighting schedule without basic inquiries to determine what parts of the building would be impacted. As a result, they did not know the washroom lights would be off and did not consider the fact that warehouse employees used that washroom.

[112] This was not simply a situation where there was inadequate lighting. There was no lighting in the washroom for an hour every day for at least two months. It could have been easily avoided and easily detected.

[113] The problem continued undetected for two months before Mr. David's fall. It was changed after Mr. David's fall but only because the Brick decided to change the lighting schedule, not because the problem was detected. Apparently, it continued undetected in part because the Brick did not do its safety inspections before 10:00 a.m. and in part because the warehouse manager and warehouse employees did not report that the lights weren't on.

[114] Employees bear some responsibility for not reporting that the lights in the washroom were not on. As Judge Tufts said in *Meridian* at para. 13:

> The foundation of the Act is the internal responsibility system, … which is based on the principle that workplace safety is a shared responsibility and the primary responsibility is the function of each party's authority and ability to control the workplace.

[115] However, the Brick's managers had the authority to change the lighting schedule and they did so without consultation or warning. That authority and ability to control the workplace gives the Brick the primary responsibility for the offence.

[116] The Brick's conduct in failing to have lighting in the washroom was not intentional but was high on the spectrum of intent. They were negligent with virtually no evidence of diligence to prevent that failure. The risk of harm and the potential consequences were significant. As such, the subjective gravity of the Brick's offending behavior for count three is high.

[117] I will turn next to counts two and four.

[118] The Brick had an adequate lighting policy and an adequate accident investigation policy.

[119] However, they did not take steps to ensure that those policies were followed. Both were in the *OHS* binder but employees did not know where the binder was kept and none had looked at it. None of the employees or managers were at all familiar with the lighting policy or sufficiently familiar with the accident investigation policy. Orientation modules did not sufficiently address either. The two managers who had obligations under the accident investigation policies received inadequate training and did not fully understand their duties.

[120] It was the Brick's responsibility to implement the policies. The subjective gravity of these offences is lessened because the Brick had adequate policies, made

some efforts at safety education and training, and had some safety checks in place to monitor compliance with policies. These were not enough to satisfy due diligence but are relevant to my assessment of the gravity of their conduct. There were risks associated with the failure to implement these policies. The failure to implement the lighting policy risked issues with lighting in all parts of the building. The failure to implement the accident investigation policy risked the loss of important evidence, the failure to detect reportable accidents, and the failure comply with important reporting obligations.

Sentencing Objectives

[121] The overall purposes of sentencing are to be accomplished by imposing just sanctions that have one or more of the objectives that are set out in s. 718.

Denunciation and Deterrence – General and Specific

[122] The primary objective of sentencing in *OHS* cases is deterrence (*Cotton Felts Ltd*., p. 294; *R. v. New MexCanada Inc*., 2019 ONCA 30).

[123] In *R. v. New Glasgow (Town),* 2008 NSPC 15, at para. 36, the Court also commented on the importance of retribution:

> While deterrence is a paramount factor, the court must also consider retribution. It is a way to condemn the behaviour involved and to reinforce the moral value of the standard that was violated. While to some, these may seem to be technical violations, the sentencing is a way to make clear that the failure to follow them and taking risks of the kind taken here, are not merely technical issues. These failures have very real human consequences.

[124] Meaningful consequences are required to send a message to other employers about the importance of safety.

[125] The Brick took action to deal with some of the issues uncovered by this investigation, prosecution, and trial. They did not wait for the trial decision. That action is relevant to specific deterrence and the need for rehabilitation. Prior to being charged, the warehouse was moved to a different location with a better lighting system. Upgrades to the lighting system have been made that cost the Brick $27,000 (Ex. 1, Sentencing Hearing). The system includes lights in washrooms that are on all the time, emergency lighting in the hallways, and generators.

[126] The Brick tried to have a robust health and safety regime and had some policies beyond what was required. However, through counsel they have recognized that what they were doing was not as thorough as it should have been. They have made changes to their reporting structure. Most importantly, they have hired a health and safety coordinator for Atlantic Canada (C.V., Ex. 2, Sentencing Hearing). Part of her duties is to make health and safety concerns more local. Since she started in November of 2021, she has been training managers in Atlantic Canada on accident investigations.

[127] Given the circumstances of the Brick, including the lack of a prior record for safety violations and their post-offence conduct, specific deterrence is not a real concern in this case.

Rehabilitation

[128] Rehabilitation contributes to the long-term protection of society. It continues to be a relevant objective, even in cases requiring an emphasis on denunciation and deterrence (*Lacasse*, para. 4).

[129] Rehabilitation and reform are recognized as relevant objectives in the *OHSA* (see *Nova Scotia Power*, para. 27).

[130] The Brick did not plead guilty. A guilty plea demonstrates remorse and acceptance of responsibility for the offence. However, the absence of a guilty plea cannot be equated with lack of remorse or a refusal to accept responsibility. Both can be demonstrated in other ways, for example, the concrete actions taken by an offender following an offence. Further, I accept Mr. Nakonechny's comments at the sentencing hearing as an expression of the Brick's remorse.

Secondary Principles

[131] There are also important secondary principles that I must consider, including:

- the principle that a sentence should be increased or reduced to account for relevant aggravating and mitigating factors relating to the offence and the offender;

- the principle of parity, meaning that a sentence should be similar to sentences imposed on similar offenders for similar offences committed in similar circumstances; and,

- the principle of restraint, meaning that a sentence should not be more punitive than is required to respond to the principles of sentencing.

(*Criminal Code*, s. 718.2; *Parranto*, para. 10).

Aggravating and Mitigating Factors

[132] Section 718.2 requires that I consider the aggravating and mitigating factors relating to the offence and the offender. Section 718.21 sets out additional factors that I must take into account when imposing a sentence on an organization such as the Brick. Some of these factors have already informed the proportionality analysis.

[133] A few require additional commentary.

[134] The Brick did not plead guilty so it does not have the benefit of that as a mitigating factor. However, this cannot be used as an aggravating factor. A guilty plea spares participants the impact of an emotionally difficult trial and is generally viewed as an indication of remorse and an acceptance of responsibility.

[135] There is no evidence that the fine proposed by the Crown would have an impact on the economic viability of the organization or the continued employment of its employees (s. 718.21(d)).

[136] Section 718.21(j) requires that I consider measures taken by the Brick to reduce the likelihood of it committing a subsequent offence. I summarized these measures when I discussed specific deterrence and rehabilitation. Post-offence corrective action should not always be considered a significant mitigating factor (*Ontario (Labour) v Flex-N-Gate Canada Company*, 2014 ONCA 53, paras. 21, 23 and 30; and, *R v New Glasgow (Town)*, 2008 NSPC 15, paras. 51-52, 54). The rationale was explained by the Ontario Court of Appeal in *Flex-N-Gate*:

> [21] The philosophy of the *OHSA* is to promote a health and safety system that relies on the internal responsibility and voluntary compliance of individual employers. In other words, workers are best protected when their employers install procedures in their workplaces that will prevent accidents from occurring. Rewarding an employer for taking corrective action only in response to an inspector's order reduces an employer's incentive to take this action before an accident occurs.

> …
>
> [23] Deterrence is undermined by treating statutorily required compliance as a mitigating factor on sentence. Rewarding an employer for action that it should have taken before an accident happened creates an incentive to put off compliance.
>
> …
>
> [30] If, after having contravened a safety standard, an employer then acts to correct the problem, it is not "doing the right thing"; it is doing what the statute requires it to do. It ought not to be "rewarded" for its compliance.

[137] In summary, the aggravating factors I have considered are as follows:

- The failures that resulted in the offences provided the Brick with an unquantified financial advantage. I infer that the decision to change the lighting schedule was motivated by cost-cutting and I accept that there is a general cost-savings in not having proper education and training (s. 718.21(a));

- Inadequate illumination is an element of the offence, so not an aggravating factor, but it is aggravating that for a portion of each day there was zero illumination in the washroom;

- The inadequate lighting in the washroom continued undetected for at least two months (s. 718.21(b));

- The potential harm from the failure to have lighting in a washroom was very high. There are obvious risks to health and hygiene. However, there are also real safety hazards. Washrooms are more likely to have liquid on the floor increasing the risk of slipping and falling. They also have hard surfaces and no carpeting which elevates the risk of serious injury from a fall;

- Key personnel who were responsible for making decisions about lighting and had important obligations in accident investigation had very little understanding of the relevant policies;

- No one from the Brick called Mr. David to check on him for 30 hours and no one called any member of his family to let them know he had been taken to hospital. That had devastating effects on the victims which are heightened

because they are African Nova Scotian and experienced what happened as anti-Black racism;

- The failure to ensure that the investigation policy was implemented contributed to flaws in the investigation which created a real risk that evidence was lost;

- The failure to ensure the lighting policy was implemented contributed to the substantive offence of failing to have adequate lighting in the washroom but also created a risk of other issues with lighting; and,

- There is a public cost to the investigation, prosecution, and trial (s. 718.21(e));

[138] The mitigating factors I have considered:

- The Brick took measures after the offence that will reduce the likelihood of it committing a subsequent offence (s. 718.21(j));

- The absence of a prior record to the extent that it reduces the need for specific deterrence and increases the hope for rehabilitation and reform; and,

- The directing minds of the organization have demonstrated an acceptance of responsibility and expressed remorse.

Parity / Range of Sentences

[139] Section 718.2(b) also requires that I consider the principle of parity. Within reason, a sentence should be similar to sentences imposed on similar offenders for similar offences.

[140] Parity is also related to proportionality. To arrive at a proportionate sentence, I must consider sentences imposed in other cases (*Parranto*, para. 11; *Friesen*, para. 33).

[141] Each sentence must reflect the unique circumstances of the specific offence and specific offender. However, situating a given case within the range of sentences generally imposed for a given offence promotes consistency, fairness, and rationality in sentencing and "gives meaning to proportionality" (*R. v. Dawson*

& Ross, 2021 NSCA 29, para. 94; *Parranto,* para. 33; *Lacasse,* para. 6; *Friesen,* para. 33).

[142] As a comparator, the Crown and Defence have both focused on *Nova Scotia Power*. I have reviewed many sentencing decisions in this context and I agree that *Nova Scotia Power* is the most useful.

[143] In *N. S. Power,* the company pleaded guilty to one safety violation for failing to ensure proper fall protection equipment. The Court imposed a total financial penalty of $40,000 (excluding victim fine surcharge). It was not proven that the violation caused the death. However, it caused a real hazard with the potential to cause serious injury or death. The employer was a large company with only one dated previous conviction for an *OHSA* offence. The employer took significant steps after the death to improve safety and was able to show that it was committed to maintaining a safe workplace.

[144] The Defence also refers to *R. v. O'Regan Chevrolet Cadillac Ltd.,* 2010 NSPC 68. In that case, the corporate accused pleaded guilty to *OHSA* offences involving failure to provide safety training and failure to have adequate safety procedures. The court imposed a global financial penalty of $30,000 (excluding victim fine surcharge) and the company was directed to present a session on workplace safety. A worker died as a result of an explosion with unknown cause. The court found no causal connection between the offences and the fatality and distinguished it from cases where the offences caused the death. The company was relatively large with 90 employees and annual profits of more than a million dollars. Prior to sentence, the company had taken steps to improve its safety system and to commemorate the employee who had died, both of which were paid for by the company.

[145] I have also considered *R.D. Longard Services Ltd.* The company was found guilty of two safety offences. The court imposed a fine of $35,000 (plus a victim fine surcharge) and a requirement that the company make a series of presentations totalling 150 hours. The worker, an electrician, died when he worked on an energized system. The Court found no direct connection between the safety violations and his death. Rather, the absence of formalized safety policies and practices created unsafe conditions for the victim and other employees. The Court could not say that the death would have been prevented if the safety provisions had been complied with, but the odds would have been reduced (paras. 27 – 31). The company was small and no longer in business at the time of the sentencing and

thus had limited ability to pay. It had no prior *OHSA* convictions and was in the process of developing a safety program for the company.

Restraint and Totality

[146] Finally, s. 718.2 requires me to consider the principle of restraint. This principle means that a sentence should not be more punitive than is required to respond to the principles of sentence (*Code,* s. 718.2; and *Parranto,* para. 10). It requires, in both the criminal and the regulatory context, that a sentence be a measured response to crime (*Nova Scotia Power*, para 56).

[147] As stated by Justice Paciocco, speaking for a unanimous Court of Appeal in *New MexCanada Inc.* at para. 82, the principle of restraint "reflects the inherent notion of fairness that although sentencing must at times occur in the public interest, punishment should not be more aggressive than the public interest requires."

[148] This principle can influence the quantum of a fine, and "applies as much in sentencing for regulatory offences as it does in the criminal sphere" (*New MexCanada Inc.,* para. 82).

[149] The principle of totality is a form of restraint and a function of proportionality that applies when consecutive sentences are imposed (*R. v. M. (C.A.),* [1996] 1 S.C.R. 500, para. 42; *Parranto,* para. 251). The principle of totality reminds us that combined sentences should not be "unduly long or harsh" (s. 718.2(c)). The terms "long and harsh" as used in the *Code* are generally considered in the context of imprisonment. However, the principle of totality applies in a modified form to regulatory offences where fines are imposed (*Alberta Health services vs. Bhanji*, 2017 ABCA 126, para. 48). In the fine context, it means that, cumulatively, the fines for an offender should reflect the gravity of the whole of the offending conduct.

Application of Principles

[150] We often think about occupational hazards and safety in the context of businesses like the construction industry, manufacturing, or mining. This case is a reminder that even businesses that do not expose workers to typical hazards have to guard against complacency toward safety.

[151] The sentence proposed here is a fine. The amount of a fine must be substantial enough to meaningfully accomplish the objectives of sentencing. It must denounce the conduct, deter other companies from committing similar offences, promote a sense of responsibility in the offender, and contribute to acknowledgement of the harm done to the victims and to the community. It cannot be seen as simply a cost of doing business.

[152] In *Cotton Felts Ltd.*, the Court said that:

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

[153] The Court also noted that "[s]entencing for this type of offence cannot be achieved by rote or by rule" (para 18). This point was reiterated by the Ontario Court of Appeal in *New MexCanada Inc.*, an occupational health and safety case involving a fatality, where Justice Paciocco said the sentencing inquiry "is more subtle" than simply determining whether a sentence would be an effective deterrent and involves "a careful examination of the circumstances of the offence and the offender, and a determination of what a fair and effective sentence would be in those circumstances (para. 97).

[154] There are similarities between this case and *Nova Scotia Power*. The companies are both large with very good safety records and both took steps to improve safety at the workplace after the offence. In *Nova Scotia Power,* the Court concluded that the protections may have prevented the death. In this case, I was not persuaded beyond a reasonable doubt that the Brick's failures contributed to the death. However, I accept that the failure to have any lighting in the washroom created a real hazard with the potential to cause serious injury or death. There are other aggravating factors that are present here that were not present in *Nova Scotia Power* and Nova Scotia Power pleaded guilty which spared the family the emotional impact of a long trial and freed up valuable court time, a benefit that the Brick doesn't have.

[155] In *Longard,* like here, it wasn't proven that the death would have been prevented if the safety provisions had been complied with and the company did not plead guilty. However, the company was small and at the time of sentence, was in debt and no longer a viable company. That factored into the quantum of fine.

[156] In *O'Regan,* the company was relatively large and the Court found no causal connection between the offence and the death. However, unlike the Brick, the company pleaded guilty.

[157] When considering the fines that were imposed in *Nova Scotia Power* ($40,000), *O'Regan* ($30,000) and *Longard* ($35,000), it is relevant that those cases were decided in 2008, 2010, and 2015, respectively.

[158] For purposes of parity, when applying precedents for fines against an organization, the impact of inflation must be factored in - $40,000 in 2008 is not equivalent to $40,000 in 2024. Fine amounts that remain static while costs, wages, and profits increase do not accomplish the objectives of sentencing. A fine of $40,000 imposed in 2024 simply does not have the same deterrent and denunciatory value as the same fine imposed in 2008.

[159] Here, I am sentencing the Brick for three offences. Ultimately, I am required to impose a fine that, cumulatively, reflects the gravity of the whole of the Brick's offending conduct and respects the principles of sentencing. To do that, I am instructed to first determine the appropriate sentence for each individual conviction. All fines will be cumulative not concurrent, so I must then take a final look at the total sentence and reduce it if required to reflect totality (*R. v. Adams*, 2010 NSCA 42; and, *R. v. Laing*, 2022 NSCA 23).

[160] I conclude that count three – the failure to provide lighting in the washroom - is the most serious offence and requires the highest penalty. The Brick's conduct was not intentional but was high on the spectrum of intent. They were negligent with virtually no evidence of diligence to prevent or detect the failure. The risk of harm and the potential consequences were significant.

[161] Counts two and four – the failures to implement policies - are, in my view, less serious. I would characterize the Brick's failure in relation to their policies as complacency. However, the potential risks of failing to implement their policies are broader but less acute than the substantive offence. If I were sentencing for counts two and four alone, I would conclude that their gravity is similar to each other so they should attract the same penalty. However, given the significant

factual and legal overlap between counts three and four, the penalty for count four should be reduced to avoid a total sentence that is disproportionate to the Brick's overall culpability.

[162] The Defence submits that a total fine of $20,000 to $30,000 would satisfy the principles of sentencing. I do not agree. A fine in that range for even one of the offences would not be within the range of sentences imposed in other cases, would not be proportionate, and would not achieve deterrence. As a penalty for all three offences, it falls far short of achieving a proportionate sentence.

[163] Having regard to the principles and objectives of sentencing and the circumstances of the offences and the offender, including the size of the company and the scope of their economic activity, I conclude that the following fines are required:

Count two - $40,000

Count three - $55,000

Count four - $30,000

[164] The total fine is $125,000. In my view that is not harsh and excessive and, cumulatively, reflects the gravity of the whole of the offending conduct. The 15% victim fine surcharge of $18,750 will be added to that, for a total financial penalty of $143,750. I will sign an order requiring the Brick to make four educational presentations.

Elizabeth Buckle, JPC