SUPREME COURT OF NOVA SCOTIA
Citation: Cherubini Metal Works Ltd. v. Nova Scotia (Attorney General)
2009 NSSC 386

Date: 20091221
Docket: Hfx 184701
Registry: Halifax

Between:

Cherubini Metal Works Limited

Plaintiff

and

The Attorney General of Nova Scotia

Defendant

Judge: The Honourable Justice Patrick J. Duncan

Heard: September 8, 9, 10, 11, 15, 16, 22, 23, 24, 25, 29, 30, October 1, 2, 6, 7, 8, 9, 14, 15, 16, 20, 21, 22, 23, November 6, and 7, 2008

Decision: December 21, 2009

Counsel: George MacDonald, QC, for the plaintiff
Michelle Awad, for the plaintiff
Michael Pugsley, for AGNS
Duane Eddy, for AGNS

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By the Court:

INTRODUCTION

[1] Amherst Fabricators Limited (AFL) was established to operate a steel fabrication plant in Amherst, Nova Scotia. The plaintiff, Cherubini Metal Works Limited (Cherubini), was the beneficial owner of AFL at all material times to this action. Both entities were part of the Cherubini Group of Companies.

[2] In November 1998, Cherubini acquired ownership of the Amherst based building, property and equipment of the former Dominion Bridge company (DBC). AFL used the plant for production to complement an existing Cherubini steel fabrication facility in Dartmouth, Nova Scotia.

[3] AFL production ceased in July 2001, and the assets of the company were sold in 2002. The closure of the company's operations has been ascribed to many things, including subversive activities of organized labour in the plant, safety concerns, overzealous and/or incompetent regulatory oversight, poor markets and poor management. Its' failure represented a substantial blow to the reputation and

economic well being of the employer, of the employees, and of the community in which it was located.

[4] The defendant, through the then Department of Labour (DOL) was responsible for regulatory oversight at AFL. The inspection actions of three divisions of the DOL in relation to AFL are in issue. They are: the Occupational Health and Safety Division (OHSD), the Office of the Fire Marshall, and the Stationary Engineers Division (SED).

[5] The plaintiff commenced this action in August 2002 seeking compensation for its losses associated with the failure of AFL. It alleges that the defendant, in its capacity as the regulator of occupational health and safety at the plant, committed actionable tortious acts against the plaintiff which caused the plaintiff's loss. The plaintiff further alleges that these tortious acts were carried out independently, or in concert with the United Steelworkers of America ("the international") and its Local 4122 ("the local"), which union represented the employees at AFL. The action named all three of these parties.

[6] The Nova Scotia Court of Appeal, in a decision reported at *2007 NSCA38*, dismissed the claim against the union defendants on the basis that the collective agreement between Cherubini and the union gave exclusive jurisdiction over the dispute to an arbitrator.

[7] The action has continued as against the province of Nova Scotia (Attorney General) ("AGNS"). The issues have been bifurcated and this is a decision in relation to liability only.

FACTS

[8] Cherubini has been operating successfully under the ownership, and with the significant personal efforts of principals, Renato and Danilo Gasparetto, since 1972. It has enjoyed substantial growth and an excellent reputation over the years of their stewardship. As of 1998, Cherubini, through its Dartmouth facilities, was providing large scale steel fabrication products for projects in Canada and the eastern United States. These included bridges, conference centres and airports.

[9] Dominion Bridge company operated a steel fabrication business in Amherst until it went into receivership in August 1998. At its closure it had a modern facility, an apparently experienced workforce and good transportation links.

[10] In October of the same year, Cherubini made an offer to purchase DBC's assets which the Receiver accepted. The transaction closed in November, 1998. Prior to making the offer, the Gasparettos toured the facility and assessed it to be capable of meeting their corporate objectives for expanded production.

[11] They recognized that some initial capital improvements would be necessary and after acquisition expended $2.1 million to renovate and clean the plant, to purchase new equipment and upgrade other equipment, to expand the paint shop and to install new roofing over exterior crane rails.

[12] They planned for a period of negative returns and committed to a further investment of time and money in AFL. Their expectation was that the market for their products would expand as the capacity and capability of the Cherubini Group of Companies expanded. AFL was to be one part of that comprehensive approach to improving the size and profitability of the Cherubini Group.

[13] I am satisfied that these very experienced businessmen fully understood the market and the potential for the Amherst facility to be productive. No question has been raised to challenge the viability of the plan upon which the brothers based their acquisition of the DBC assets. However, there was a fundamental flaw in their business plan which assumed that AFL would employ an experienced, qualified and motivated former workforce of DBC. They were wholly unprepared for the myriad of problems that would arise from this incorrect assumption.

[14] Unfortunately Cherubini made no, or inadequate, inquiry to determine, in advance of the purchase, whether the former DBC employees would be able or willing to perform to the established Cherubini standards of production. Some senior and influential unionized employees would prove to be poorly motivated, inadequately trained and hostile to change. The Local's executive, which included some of those same employees, together with the USWA international representative, Calvin Luedee, made efforts to frustrate Cherubini in its attempts to bring the unionized employees into compliance with the Cherubini management and production philosophy. The defendant became embroiled in this dispute.

[15] This action attacks the manner in which the defendant sought to fulfill its statutory responsibilities at the AFL plant, and seeks to determine whether, by its conduct, the defendant should be held liable for plaintiff's losses at AFL.

The Union

[16] It is impossible to fully understand the relationship as between the plaintiff and defendant without examining the relationship between the plaintiff and the AFL employees.

[17] Members of the nonunion workforce were productive and motivated. Within the unionized workforce there were many employees who were similarly motivated to meet management expectations.

[18] The core of the labour problem emanated from those few senior, yet very influential members of the Local, whose goal was to guarantee that working conditions in the plant would not change from the DBC days, irrespective of the impact on the productivity, profitability, safety, and ultimately the viability of AFL.

[19] The Local's conduct was aided and abetted by Mr. Luedee, who, as the evidence demonstrated, carried an unremitting desire to assert union authority in how the AFL plant would be operated. I have concluded that Mr. Luedee carried a personal *animus* toward the Gasparettos and AFL management which influenced his judgment in how the union should interact with the employer. It is up to others to assess whether the conduct of the various union representatives constituted a disservice to the members they were employed to assist.

[20] After DBC went into receivership there was a USWA sponsored attempt to acquire the plant to be operated by the employees. That failed for lack of funding and employee commitment to the financial obligations attached to such an arrangement.

[21] Very soon after the Cherubini offer to purchase the DBC assets was accepted, the Gasparettos approached the union to negotiate a collective agreement and the quick return to work by the former DBC employees. The union lead Cherubini to believe that this was a welcome initiative.

[22] In fact, the USWA and, in particular, Mr. Luedee were unhappy with the sale and were already undertaking a legal action against the Receiver and Cherubini to seek an annulment of the sale. Media articles quoting Mr. Luedee indicated that there would be no negotiation until the legal issues were resolved. Both the action as against Cherubini, and the media releases were contrary to the spirit of the conversations between the parties and so Cherubini refused to negotiate with the union. Work to renew the plant went on without the participation of the union employees. In March, 1999, the union capitulated, withdrew the action and entered into negotiations with Cherubini.

[23] Cherubini employed the services of Matthew MacPherson to act as its' negotiator. Mr. MacPherson is an impressive person and witness. He has been a labour relations consultant since 1969, including experience as the chief spokesperson in collective bargaining on behalf of the Construction Management Bureau. It was, as he described it, a "management union". He assisted in grievance disputes, arbitrations, and mediations. He was, as at the time of trial, a member of the Labour Relations Board of Nova Scotia.

[24] Cherubini did not trust Mr. Luedee as a result of what they perceived to be his duplicitous conduct in initiating an action against Cherubini and speaking to the media, while Cherubini was seeking a collective agreement. In consequence thereof, Cherubini set as a precondition to negotiation that they would not participate if Mr. Luedee was involved. Indeed, Cherubini banned Mr. Luedee from attending at the AFL facility.

[25] Another USWA representative, John Kingston, assisted the Local in achieving the Collective Agreement in an efficient and professional manner. Negotiations were described by Mr. MacPherson as "one of the most congenial rounds of bargaining" that he had been involved in. The Agreement was complete in April, and on May 7, 1999, the plant was officially opened.

[26] The first three seeds of trouble were planted in the negotiation of, and in the provisions of, the Collective Agreement.

[27] First, Mr. Luedee, notwithstanding his evidence to the contrary, took offense to being excluded from the negotiation.

[28] Second, at Cherubini's insistence, the Collective Agreement contained substantive provisions with respect to ensuring the health and safety of the workers. In fact, Mr. McPherson said that he could not "... remember ever having to negotiate such strong health and safety language." This was embodied in Article 12 entitled "Occupational Health and Safety".

[29] Article 12.03 states:

> The union acknowledges that the Company has a "zero-tolerance policy" in respect to breaches of the Occupational Health and Safety Act and Company safety policies. Any such infractions may lead to discipline, up to and including termination of the employee.

[30] Article 13, "Pay on Day of Injury," states at 13.01:

> Provided an employee has not committed a breach of the Company's Safety Regulations, an employee who is injured on the job and, as a result, cannot continue to perform work duties, shall be paid at the employees (sic) regular straight time hourly rate for all scheduled hours remaining in the employee shift. *The JOSH (sic) committee shall be the final judge as to whether or not there has been a breach of the Company's Safety Regulations in order to determine entitlement to pay under this clause.* (emphasis added)

[31] The combined effect of these two Articles required the Joint Occupational Health and Safety Committee ("JOHSC") to engage in faultfinding where potential

safety violations occurred. If fault was attributed to the employee then there was a corresponding loss of pay. The union employees on the committee strongly opposed being put in the position of having to assign blame to fellow union members, notwithstanding that they had agreed to do so in the Collective Agreement.

[32] Mr. Luedee candidly acknowledged that he would never have agreed to the provisions of Articles 12 and 13 if he had been at the negotiating table.

[33] Third, the union accepted responsibility for the development of a seniority list which it was to provide to management. That list was never provided and, as a result, a number of grievances were generated when the company made necessary decisions that variously impacted employees claiming seniority privileges. Each attempt by the employer to develop a Classification Seniority list was summarily rejected by the union, without the union being able to provide a suitable alternative.

[34] In what can only be described as an assault on the company, the Local, with the active encouragement and advice of Mr. Luedee, engaged in a multi pronged

attack on the employer. The evidence shows that members of the Local and/or Mr. Luedee:

i) abused the grievance procedure;

ii) engaged in a pattern of non cooperation in the work of the JOHS Committee;

iii) made unilateral complaints to field and supervisory personnel in the Department of Labour, which were not disclosed to the employer, and omitted material facts or misrepresented material facts when communicating their concerns and complaints to DOL;

[35] There is also evidence from which one could infer that members of the union engaged in deliberate acts intended to slow down productivity, including damage to company equipment and property and adopting “slow down” work performance strategies. Whether that inference is accurate is not material to this decision and so I make no findings with respect to these allegations.

Grievances

[36] The union filed 101 grievances from August 3, 1999 through December 7, 2001. There was one grievance filed in 1999. 11 more were filed between January 1, 2000 and July 31, 2000. In the period August 1, 2000 through December 31, 2000 there were a further 48 grievances filed, making a total of 59 grievances for the year 2000. The balance, 41 grievances, were filed in 2001.

[37] Approximately 38 grievances were identified as being a result of unjust layoffs, seniority issues or an unjust reduction in pay. To the extent that these related to the classification Seniority List, that problem stemmed largely from the union's inability to provide management with an acceptable seniority list. There was some disagreement as well over the interpretation of Article 10 of the Agreement, which addressed seniority accrual.

[38] Approximately 18 grievances that were filed in October and November of 2000 arose from a dispute over the calculation of break times. The company expected employees to be at their workstations at the commencement of the shift, at the beginning and at the end of their 10 minute breaks, and at the end of the

shift. The employees felt that they only had to be in the plant and en route to their workstation at these times. The company was concerned because of loss of productivity when, for example, a 10 minute break was expanded by several minutes while employees travelled to and from their workstation to the place where they enjoyed their break.

[39] In June, 2001, Brian Guthro, an employee and Local vice president, was suspended as a result of his repeatedly being away from his workstation during shift. This generated an illegal work stoppage by AFL unionized employees and resulted in three of them being discharged. These included the union president, Barry Cormier, vice president Guthro, and Bruce Harrison.

[40] Mr. McPherson was sometimes consulted by plant managers at the first stage of the grievance procedure, but was consistently to participate in stage two. He described the number of grievances at this plant as beyond any previous experience that he had.

[41] Mr. McPherson described his past dealings with Mr. Luedee as well as their interaction in the grievance process at AFL. Interestingly, Mr. Luedee claims not

to have been previously familiar with Mr. McPherson. I reject his evidence in this regard. Mr. McPherson says that he dealt with Mr. Luedee in labour relations at the Trenton Carworks. He found Mr. Luedee to be "obnoxious, rude, adversarial" and a "strict positional negotiator". In his attempts to address the resolution of grievances at AFL he found Mr. Luedee to be "threatening, intimidating, unproductive" and showed no effort to achieve resolution of the grievances.

[42] Mike DeWare, the AFL plant manager from January, 1999 to March 31, 2000, wrote a letter to the Local on February 21, 2000 complaining about Mr. Luedee's behaviour in a Step 2 Grievance meeting and expressed frustration with his obstructionist conduct. He objected to the fact that when Mr. Luedee came into the meeting his first comment was to address Mr. McPherson as an "asshole" and then stated that it was a "poor fucking excuse for a collective agreement".

[43] After production at the plant ceased, Bruce Outhouse Q.C. was engaged by the parties to resolve the outstanding grievances filed by the employer and by the union, as well as a **Trade Union Act** complaint that the union filed. Hearings were held over eight days in 2001 and 2002 with Mr. Outhouse's decision issued on

January 22, 2002. All but 13 of 87 grievances outstanding at the beginning of Mr. Outhouse's hearings were settled before he rendered his report and decision.

[44] The evidence demonstrates that responding to and participating in the grievance process consumed time and resources which impacted on productivity. Simply put, when managers, staff and floor workers were participating in the grievance process they were taken away from their normal duties. Employing legal and labour relations consultants also cost AFL money. The union approach to the grievance process generated frustration for the managers of AFL and contributed to the poor relations between the employer and the union.

[45] The defendant's actions in the inspections of AFL were sometimes generated by union complaints that there were safety issues in the plant. It is significant that the union never filed a grievance alleging a safety concern. They did not report complaints to the employer, nor to the JOHSC, notwithstanding a statutory requirement to do so. Section 17 of the **Occupational Health and Safety Act** S.N.S. 1996, c. 7 (**OHSA**) says:

> 17 (1) Every employee, while at work, shall

(1) (a) take every reasonable precaution in the circumstances to protect the employee's own health and safety and that of other persons at or near the workplace;

(b) co-operate with the employer and with the employee's fellow employees to protect the employee's own health and safety and that of other persons at or near the workplace;

(c) take every reasonable precaution in the circumstances to ensure that protective devices, equipment or clothing required by the employer, this Act or the regulations are used or worn;

(d) consult and co-operate with the joint occupational health and safety committee, where such a committee has been established at the workplace, or the health and safety representative, where one has been selected at the workplace;

(e) co-operate with any person performing a duty or exercising a power conferred by this Act or the regulations; and

(f) comply with this Act and the regulations.

(2) Where an employee believes that any condition, device, equipment, machine, material or thing or any aspect of the workplace is or may be dangerous to the employee's health or safety or that of any other person at the workplace, the employee shall

(a) immediately report it to a supervisor;

(b) where the matter is not remedied to the employee's satisfaction, report it to the committee or the representative, if any; and

> (c) where the matter is not remedied to the employee's satisfaction after the employee reports in accordance with clauses (a) and (b), report it to the Division. 1996, c. 7, s. 17.

[46] The officials of OHS entered into their inspections without inquiring whether the union had fulfilled its statutory responsibility. This occurred despite ample information to suggest that a healthy cynicism should be applied to the complaints of Mr. Luedee in particular.

Joint Occupational Health and Safety Committee

[47] Section 29 of the **OHSA** states that in a plant like AFL, an employer "... shall establish and maintain one joint occupational health and safety committee...". Sections 30 and 31 of the **Act** provide for the composition and procedures of the committee, as well as its functions.

[48] Articles 12 and 13 of the Collective Agreement between AFL and the Local contain provisions for compliance with Sections 29-31 of the **OHSA.**

[49] The JOHS committee was established shortly after the plant opened in May, 1999 and met on a monthly basis. It carried out tours of the plant, reviewed

employee concerns that were brought to their attention and made appropriate recommendations. Follow-ups were performed to ensure action was taken on their recommendations. Notwithstanding union member reservations about the fault finding requirements, they participated in committee investigations of accidents and near misses, and other conduct which could support a finding of a breach of safety regulations or policies. They made decisions and recommendations.

[50] Derek Nickerson is the current Health and Safety Officer for the Cherubini Group of Companies and has been so employed since 2005. He succeeded Mike DeWare as plant manager of AFL in March, 2000. He initiated regular "Labour Relations Meetings", the first of which was held on April 26, 2000. It was an attempt to improve communications between management and labour.

[51] As of May 5, 2000, the Local was made aware that the company was beginning to monitor employee production.

[52] By June 22, 2000 Mr. Nickerson concluded that the JOHS committee was not "getting the big things done" and "not finalizing some things fast enough".

[53] On September 8, 2000 the issue of training for JOHS committee members was addressed. Two members from management went to a course but the two union representatives refused to go. Initially they indicated that they did not have transportation to Halifax, but when transportation was offered they said they would not go.

[54] By November 2000, Mr. Nickerson felt that the facility was suffering from the negativity stemming from what he characterized as " controversy" and "confusion". It created stress for everyone, even office support staff. He testified that in his opinion every step he took to manage the facility was blocked by the union members.

[55] At the Labour Relations meeting of November 23, 2000 Mr. Nickerson first learned that the union had privately communicated to Alan Ross, the OHSD inspector, that the JOHS committee was not working properly. They expressed concerns over the fault finding question. This was the first time that Mr. Nickerson became aware of the degree of the problem. He suggested that the union should bring their concerns to him, as the Plant Manager. As well he offered to send the members on training.

[56] He believed the JOHS committee was "still working to some degree" but that they were struggling with faultfinding issues. Mr. Nickerson testified that, in his view, this was an issue of the enforcement of the agreed-upon terms in the Collective Agreement. He formed the opinion that involvement of DOL on this question would serve to undermine his ability to manage the facility.

[57] In a letter of December 5, 2000 Mr. Nickerson wrote to the Local to reinforce their responsibility to attend JOHS committee meetings.

[58] On December 19, 2000, Alan Ross conducted an inspection of AFL. In his inspection report he states in relation to the Internal Responsibility System Evaluation:

> The "Corrective Action Report" prepared by the JOHSC at Amherst Fabricators includes a determination of who is at fault. The determination of fault *may* be contrary to accepted loss control and accident investigation practices as it *may* deter reporting of incidents whose investigation may lead to the prevention of future accidents. (Emphasis added)

[59] Mr. Nickerson was extremely concerned as, in his view, he needed to understand what had happened in an accident in order to take appropriate

corrective actions. He held the opinion that Mr. Ross' comment ran contrary both to the Collective Agreement and to the philosophy of the **OHSA**.

[60] Of greater concern was that in the meeting of the JOHS committee on January 12, 2001 committee members questioned whether they were obligated to find fault having regard to the opinion expressed by Mr. Ross. Mr. Nickerson felt that this was a clear example of Mr. Ross, in his capacity as an inspector for DOL, interfering with the bargaining unit by stating that they were not required to perform a function they agreed to in the Collective Agreement.

[61] On January 18, 2001 the JOHSC minutes reflect that Mr. Nickerson threatened to dissolve the existing committee and get new members who would live up to the requirements of the Collective Agreement.

[62] Other significant events such as the Joint Evaluation of March 6, 2001, soon overtook the problems in the JOHS committee. It continued to meet until the plant was closed. The union members never accepted their responsibilities of faultfinding under the collective agreement.

Complaints to DOL

[63] Union members and their representatives were disrupting the company internally in ways already outlined. Simultaneously, they were bringing complaints to the regulator at both the field and supervisory levels. The complaints were framed as concerns over safety, and seemed intended to paint AFL as an unsafe workplace, and to harass the company with regulator oversight in the form of inspections and compliance orders.

Trenholm Accident Complaint

[64] In June, 2000, Ron Trenholm, a unionized employee at AFL, was rigging in the yard. He was collecting beams to put them on a conveyor. He testified that he had both the experience and training to conduct this task safely but through his own fault suffered an injury accident in the process.

[65] On June 20, 2000 a Corrective Action Report was issued by the JOHS committee in which Mr. Trenholm was found at fault in relation to his accident. The next day Mr. Luedee and Mr. Cormier telephoned James LeBlanc, Executive

Director of the OHSD, listing a series of concerns in relation to crane operator training that had never been raised in previous JOHS committee plant audits, and which had not been discussed with the employer as required by Section 17 of the **OHSA**. Some of the information in Mr. LeBlanc's notes, that is attributed to Mr. Luedee and Mr. Cormier, was incorrect.

[66] Neither of Mr. LeBlanc nor Mr. Ross questioned the appropriateness of the information coming directly to them, or its accuracy.

Manship Accident Complaint

[67] Mr. Manship operated a travelling crane and was determined to be at fault in relation to three accidents that occurred in July and August of 2000. The investigation indicated that the cause was operator error.

[68] In relation to the last incident, a suggestion that the travelling crane brake malfunctioned was rejected. In the result, Mr. Manship was suspended. On August 21 a union grievance was filed, and on August 23 a meeting was held in which it was determined that there was no issue with the travelling crane brake.

[69] In that meeting, Mr. Manship admitted making errors in marking the load slip, and acknowledged that he had been given instructions and verbal warnings on performance as a result of earlier incidents. The union indicated an intention to grieve the one day suspension that was handed to Mr. Manship.

[70] On August 24 Mr. Luedee called Mr. LeBlanc to complain that Mr. Manship has been suspended. Mr. Luedee alleged that "Everybody knew that the brake on the crane was not working", and that it had not been functioning properly since the plant reopened in May of 1999. In fact the crane had been inspected by Atlantic Crane and Regulators on an earlier occasion and found to be in good working order. Mr. Luedee's allegation was contrary to the evidence, as well as the findings of the JOHS committee.

[71] Mr. LeBlanc tasked Mr. Ross to look into the allegation, as he was servicing AFL. Mr. Ross attended at the plant on August 24, 2000 and issued compliance order 530327-01 requiring the employer to provide him with copies of the most recent hoist inspections.

[72] Neither of Mr. LeBlanc nor Mr. Ross inquired as to the JOHS committee conclusions, though they would have been available to them. When shown the Corrective Action Report at trial, Mr. LeBlanc agreed that it appeared that the JOHS had properly performed its work in relation to the Manship incident.

JOHS Committee Training Complaint

[73] In September, 2000, members of the JOHS committee were offered the opportunity to attend training. Union members refused at that time notwithstanding the fact that the employer would pay for it and provide transportation.

[74] On November 24, 2000 the JOHS committee minutes reflect that the union members were scheduled to be sent for training.

[75] In a meeting of the Local on November 29, 2000 Minutes recorded that "Aubrey and Marty to Halifax for two days in December for JOHS training". The evidence shows that Mr. Luedee was present at that union local meeting and so presumably was aware of this fact. Mr. Luedee called James LeBlanc on November 30, 2000 to say that the employer was not providing training for the union representatives on the committee. Mr. LeBlanc accepted this without question and wrote to Mr. Ross on the same day advising them of Mr. Luedee's complaint.

[76] Mr. Ross attended at AFL on December 19, 2000, conducted an inspection and immediately issued orders to the employer directing them to provide training to members of the committee, to provide them with time off work as necessary to attend meetings and to pay the cost of the training. This was all generated on the patently untrue information provided to Mr. LeBlanc by Mr. Luedee and which went unquestioned by either Mr. LeBlanc or Mr. Ross.

Springhill Meeting /Joint Evaluation

[77] The union leadership had a unilateral meeting with DOL representatives in Springhill on January 15, 2001 at which they provided information, some provably inaccurate, upon which the OHS Division relied when it directed that a broad general inspection, characterized as a "Joint Evaluation" be conducted at AFL on March 5 and 6, 2001. This will be addressed in greater detail at a later point.

Respirator Complaint

[78] In some instances, the union motives were less sophisticated. For example, in April 2001, the company established a "use of respirator" policy. Local President Barry Cormier did not want to comply with directions to wear a respirator. He complained initially that the mask did not fit properly, and that it would not serve the purpose for which it was intended. He raised it at a JOHS committee meeting and employer testing demonstrated this to be without foundation.

[79] He complained that the respirator was "flaking" and unsafe. Eventually the respirator was tested and determined to be appropriate.

[80] He attempted to claim a medical exemption which was denied.

[81] Finally, Mr. Cormier indicated that he would file a grievance over the requirement to wear a respirator.

[82] Mr. Nickerson thought he had resolved the issue by providing Mr. Cormier an accommodation on May 31, 2001. Notwithstanding this, Mr. Luedee contacted Mr. Ross on June 4, 2001 seeking that Mr. Ross go to the plant over the respirator issue, which Mr. Ross agreed to and did do. In this instance, DOL satisfied itself that the employer's position was correct.

The Department of Labour

[83] Steel fabrication is an inherently dangerous industry. The occurrence of injury accidents is virtually inevitable. Safety must be a concern for the employer and the employee. The public has an interest in safe workplaces. An injured worker is no longer contributing to the economic growth of the community, and

may become a burden on the taxpayer through the demand put on health and income assistance. At the times material to this action, it was the responsibility of the Department of Labour to oversee the safety of Nova Scotia work places such as that of the plaintiff.

[84] The DOL's regulatory oversight of AFL was undertaken by different divisions. Relevant to this action are the actions of the Office of the Fire Marshall, the Public Safety Division and the Occupational Health and Safety Division.

[85] The Department was headed by a Minister of the provincial government. Kevin McNamara was the Deputy Minister at the relevant times to this matter. Each of Public Safety and Occupational Health and Safety Divisions were headed by a Director.

[86] James LeBlanc was the Director of Occupational Health and Safety Division. Under him there was a Provincial Manager, and Regional Managers, who in turn guided the activities of officers/inspectors within their territories. While primary inspection of a company was managed within the region, managers

and officers could be brought in to assist in the inspection and oversight of companies operating in another territory.

[87] The plaintiff submits that it was in compliance with all regulatory requirements but that, notwithstanding its' efforts, it was subjected to inspection and compliance action by DOL officials that were abusive, discriminatory, unnecessary and/or incompetent.

[88] The defendant says that the actions taken by its employees were performed appropriately, competently, in good faith, and within their statutorily authorized authority as regulators.

[89] I will turn now to an examination of the facts underpinning this dispute.

Office of the Fire Marshall: The Liquid Propane Problem

[90] Cherubini intended to use liquid propane in the AFL plant for heat, and to supply the cutting tables. During its startup phase Cherubini retained Superior

Propane Inc. to make necessary installations and modifications to the existing system.

[91] The **Fire Prevention Act** R.S.N.S. 1989, chapter 171, (since repealed and replaced by the **Fire Safety Act** S.N.S. 2002) and regulations made pursuant thereto, assigned to the office of the Fire Marshall authority and responsibility for the provision of fire safety in buildings and for safe storage of flammable and combustible materials.

[92] Under Section 8 of the **Act** the Fire Marshall had "full power and authority to enforce compliance with ... the L. P. Gas Installation and Equipment Regulations". Section 16 (1) (c) of the **Act** gave the Fire Marshall authority to enter and inspect any building or premises to ascertain whether combustible or explosive materials were present, or whether other inflammable conditions existed that could endanger life or property. Section 16 (2) provided the Fire Marshall discretion to order that within a reasonable time the occupier was required to remove, or keep secured the combustible or explosive material, or to otherwise remedy the inflammable conditions. Section 22 gave a right of appeal to the owner

or occupier of a building affected by an order of the Fire Marshall made pursuant to Section 16.

[93] The office of the Fire Marshall was at all material times a division of the Nova Scotia Department of Labour.

[94] Stephen Pilon was employed as a Liquid Propane Gas Inspector by the Fire Marshall's office in 1999. He was tasked to ensure that Superior Propane met appropriate safety standards of the day in the installation and distribution of propane storage and supply at the AFL plant.

[95] The plaintiff has not challenged Mr. Pilon's authority, but says that he lacked adequate technical knowledge to assess the appropriate safety requirements for use of propane in a steel fabrication plant in the way proposed by AFL. It is alleged that by his conduct substantial and unnecessary delays and costs were incurred by AFL.

[96] On May 4, 1999 Superior Propane requested a temporary installation to get some cutting torches and an automated cutting table working at the AFL plant. The

Fire Marshall gave permission but indicated that the installation must be completed within four weeks and "to Code".

[97] On May 31, 1999 Mr. Pilon conducted a site inspection at AFL. Arising from that inspection he issued an Order to Remedy, number 99-124, to Superior Propane. The Order, dated June 17, 1999, listed eight deficiencies. If they were not resolved to the satisfaction of the Fire Marshall within 60 days then all propane deliveries to the site were to cease. If propane supply to the plant was terminated it would cause production to stop. As a result, Mr. DeWare retained Jack Miner to provide advice in response to the Order. Mr. Miner is the President of Atlantic Regulator and Torch Repair and is familiar with welding and repair requirements for industrial equipment using gas distribution systems.

[98] Some of the deficiencies were readily resolvable or dealt solely with the technician at Superior Propane. Others were perceived by AFL as being inconsistent with the safe and cost efficient use of propane in a steel fabrication plant. The most significant concern related to the following:

> 3. The "traps" located in the piping system of the torch supply does not appear to carry any certification and shall be removed from the system.

[99] Mr. Miner learned that the “traps” referred to in Mr. Pilon’s order were Hydraulic Flashback Arrestors. Mr. Miner testified that the arrestor is necessary to ensure that a flash would not get back into the bulk propane supply and that to remove it, as the order required, would create a significant safety hazard.

[100] AFL also sought out the advice of its legal counsel, Doug Tupper. He understood that management had concerns that some provisions of the Fire Marshall’s order would increase cost, reduce competitiveness and could be dangerous and inappropriate for their type of operation.

[101] Letters were issued by Mr. Tupper’s associate to the Deputy Minister for the Department of Labour, Kevin McNamara, on July 21, 1999, and to Mr. Pilon on July 22, 1999. These letters provided a point by point response to the provisions that were challenged. The concerns of AFL were expressed and in particular raised the concern for a shutdown of the plant if it could not be resolved. A letter in reply of July 26, 1999 set out Mr. Pilon’s position. He indicated that the order would not be revoked, but offered a meeting with Bob Cormier, Fire Marshall, and Dale Stewart, the Chief Gas Inspector.

[102] Mr. Tupper had previous experiences with Deputy Minister McNamara, and requested that he convene a meeting for the purpose of resolving the differences. That meeting took place on August 19, 1999. Those attending included Mr. McNamara, Mr. Pilon, Mr. Stewart, Jack Miner, Mr. Tupper and his associate, René Gallant.

[103] Mr. Tupper felt that there was a good discussion and that Mr. McNamara was working hard to understand his client' s concerns. He remembered the conversation as being largely technical and that ultimately a resolution was achieved.

[104] Mr. Miner presented the same information in that meeting that had been set out in Mr. Gallant's letter to Mr. Pilon. He formed the opinion that Mr. Pilon and his supervisors had simply paid no heed to the representations. He recalls the Deputy Minister saying: "stop, there is no need to embarrass people any further".

[105] On August 20, 1999 Mr. Pilon wrote to Mr. DeWare and advised him that time would be required to research the issues raised at the meeting of the previous

day. Conditions were established that would allow AFL to continue to operate using propane. Various correspondence was exchanged and on September 1, 1999 Mr. Pilon wrote a letter to Superior Propane providing the final response with respect to the original deficiencies. The flashback arrestors were permitted to remain in place. Some propane hoses were replaced, the cost of which Mr. Miner estimated at approximately $100.

[106] I am satisfied that the propane distribution system was misunderstood by Mr. Pilon and his conduct generated inconvenience and cost to Cherubini. Mr. Miner demonstrated a thorough understanding of the technical specifications necessary to the AFL requirements and I accept his explanation as to why the Fire Marshall' s requirements were incorrect. His evidence is consistent throughout and reflects a far more thorough understanding of the issue than that exhibited by Mr. Pilon.

[107] In summary, three months passed from the date of the site inspection until the issue was finally resolved, during which time AFL expended considerable time and money to satisfy Mr. Pilon that he was incorrect in issuing the most significant requirements contained in the Order to Remedy.

[108] I can find no evidence to support the suggestion that Mr. Pilon or anyone involved on behalf of the regulator in this matter exhibited an intent to injure Cherubini. I am satisfied that any inadequacy demonstrated by Mr. Pilon stemmed from a lack of experience and training in the particular equipment at issue in the AFL plant. I find no evidence of bad faith or malice.

[109] While it should not have taken the involvement of a Deputy Minister to have achieved this result, the plaintiff was afforded a full opportunity to present its case. There was a five-week delay from the time that Mr. Gallant expressed the AFL concerns in writing to Mr. Pilon until Mr. Pilon provided a written resolution on September 1. In particular, the matter was resolved very quickly after the August 19 meeting which appears to have been the only time that all of the principal parties sat down in a face-to-face meeting.

Stationary Engineers Division: The Crane Operator Certification Problem

[110] AFL had cranes in receiving, inside the plant, and in shipping. These were for hoisting and moving the product through the various stages of production.

[111] At a toolbox meeting of August 13, 1999 the minutes of one of two meetings held that day record that workers expressed concerns that training was needed for crane operators who were unfamiliar with their operation. Barry Cormier, the Local President was in attendance at the time.

[112] After acquiring the plant AFL retained the assistance of Atlantic Crane and Material Handling to provide safety training to the employees who were expected to operate the cranes. The evidence of Jack Miner suggests that there was no government approved course at that time and that he had gathered materials together in order to offer such a program.

[113] Robert Allen has extensive experience in the installation and maintenance of cranes. While he has never been employed nor certified as a crane operator he operates cranes incidental to their servicing, which includes load testing. Mr. Allen regularly serviced cranes at AFL.

[114] He attended at AFL, on behalf of Atlantic Crane and Material Handling, in or about August 1999 to provide training to employees in crane operation safety.

He was aware, at the time, of the provision in the **Stationary Engineers Act** R. S. N.S. 1989, c. 440, setting criteria for, and the necessity of, certification to operate a crane powered by a motor that was 25 motive horsepower (MHP) , or more. (Note: **The Stationary Engineers Act** was repealed in 2000 and replaced by the **Crane Operators and Power Engineering Act** S.N.S. 2000, c.23)

[115] The course he offered was derived from two crane manufacturers' books and a video. The materials covered crane operation and included information on rigging and hoisting. It took four hours for each employee to complete and there were approximately 20 in each class. To earn a certificate of completion from Atlantic Crane each employee watched the video, participated in an in-class review of the manual, accompanied Mr. Allen for a walk around inspection of the crane trucks to identify various parts, and wrote a true/false examination. Employees were not tested on their ability to operate a crane.

[116] Mr. Allen was unaware of the experience held by the operators in the classes. He acknowledged that the materials that he used were less intensive than the "Recommended Reading Guide for Crane Certification Examination Candidates Manual" provided by the Department of Labour.

[117] Certificates were issued to a number of AFL employees on September 2 and September 9, 1999. Mr. Allen did not return to the plant at any subsequent date to conduct further training.

[118] The minutes of the toolbox meeting held on October 21, 1999 recorded that "younger new members consult older experienced crew to help learn crane operators" [sic].

[119] The **Stationary Engineers Act** provided for the certification and regulatory oversight of stationary engineers, or persons employed to carry out tasks performed by qualified stationary engineers. The **Act** was administered by the Stationary Engineers Division of the Department of Labour.

[120] The operation of the hoisting devices at AFL could, depending on the circumstances, require the employment of a person certified under the **S.E. Act**.

[121] Joseph Simms, was an inspector for SED. He attended at AFL on March 23, 2000 and conducted an inspection. His evidence indicates that the visit was

spontaneous as he was in the area and observed cranes in the AFL yard. He had some familiarity with the Dartmouth Cherubini plant having previously inspected it in September of 1999.

[122] Mr. Simms reported to John Siggars. Mr. Siggars testified that due to the limited resources in his office, the onus was on employers to ensure that their employees were properly certified for crane operation. Inspection then consisted of spot checks, such as that conducted by Mr. Simms at AFL.

[123] Mr. Simms was accompanied in his tour of the plant by the manager, Mike DeWare. Mr. Simms observed four cranes in operation that had a lifting motor with a capacity in excess of 25 MHP. He determined that the operators did not hold required certification pursuant to the **Stationary Engineers Act** for the operation of these cranes. He issued an order the same day that stated:

> You are hereby ordered to submit a detailed proposal as to how compliance is to be achieved, with respect to having all cranes in excess of 25 MHP staffed when in operation. The date of expected compliance must be included in this proposal.

[124] Mr. Simms testified that he had the discretion to shut the cranes down for noncompliance, but chose to give AFL an opportunity to present a proposal to

bring their operation within the law. He knew that the consequence of an order forcing immediate compliance would be the shutdown of operations at the plant.

[125] He had never previously had to issue an order in relation to this issue as other plants had certified operators on site, or successfully put forward a proposal that provided for certified operators well within an acceptable time frame to the Division.

[126] Mike DeWare testified that he was not previously aware of the certification requirements for persons operating 25 MHP hoisting devices. He understood that a proposal had to be in place before June 1. At that point he was aware that AFL crane operators had received a safety course from Atlantic Crane. He also had a list, provided by the union, of employees who were so-called "designated crane operators" at Dominion Bridge. Many of these employees had in excess of 10 years experience, and some had 20 or even 30 years of experience.

[127] He spoke to Mr. Simms on March 24, 2000 to discuss solutions and then referred the question to Renato Gasparetto.

[128] The company was concerned about the order for a variety of reasons:

1. Many of their operators had substantial experience, yet due to limited literacy may not have been capable of passing a written examination;

2. They believed that it would require a number of people to be certified to operate them. In the absence of operators the plant would not be able to function;

3. It became apparent that DBC had employed the same persons as AFL in operation of these cranes, and yet DBC had not been subjected to the same inspection and certification requirements;

4. The requirement for certification by the motive horsepower was irrelevant to the safe operation of the cranes. (The evidence indicates that this was removed as a criteria in subsequent enactments);

5. Despite years of operation Cherubini had not been made previously aware of the certification requirements;

[129] Acting on legal advice, Mr. England applied to the Stationary Engineers Board of Examiners pursuant to Regulation 48 (1) which states that:

> On application from an employer, the Board may issue a certificate of qualification to an employee of the employer with long-term service in a registered plant of the employer.

[130] On April 25, 2000 Mr. Simms informed Mr. England that the Board of Examiners had refused the request. Grandfathering would only be considered after the employees failed in an attempt to write the certification exam. Mr. England responded that the company would be objecting to the denial as the regulation did not contain such a precondition for the issuance of a certificate.

[131] As a result, Mr. Tupper again met with Deputy Minister McNamara, this time on May 4, 2000. He found Mr. McNamara receptive to offering assistance to achieve a solution. On Mr. McNamara's suggestion, Mr. Tupper advised Mr. England to initiate an appeal of the order. A stay of Mr. Simms' order was granted for 60 days.

[132] At the end of July the company was advised that the order had to be complied with by August 30 or action would be taken. Mr. England wrote to the Minister of Labour indicating a formal appeal of the Board's rejection of the grandfathering request.

[133] While the appeal was ongoing, information was collected and provided to DOL setting out the names and experience of individuals that they were seeking to have qualified.

[134] On February 5, 2001, the Minister of Labour advised the company that the appeal was denied - none of the employees whose names were submitted were considered sufficiently qualified to safely operate the overhead travelling cranes in the absence of certification. The company was not prepared for such a decision and consulted its legal counsel, Mr. Tupper.

[135] On February 12, 2001 Mr. Simms attended a meeting of the Board of Examiners appointed under the **Act**. The company's appeal had been dismissed and the Board suggested to him that he rewrite his order. He did not want to do that without a reinspection.

[136] He went to AFL on the same day and determined that the cranes were still in operation by people who had not been certified. He met with Mr. Nickerson and advised him that he was going to be issuing an order, and that the only thing to discuss was the time frame in which compliance would be required.

[137] I accept that it was Mr. Simms' intention to provide AFL time in which to comply. However, when he called his supervisor, Mr. Siggars, to report on his findings he was directed to issue the order requiring immediate compliance. Mr. Siggars was unmoved by Mr. Simms' advice that this would force the immediate shutdown of the plant.

[138] Mr. Siggars testified that he felt that "we had stuck our necks out long enough" and didn't want to delay compliance any further. He feared an accident by an uncertified crane operator and that once his inspectors became aware of such a situation, they assumed some responsibility for that worker's safety. He testified that while the certification issue dragged on he was "not sleeping well".

[139] Mr. Tupper learned of the Minister's decision late on Thursday, February 8. He began the preparation of a submission to the Deputy Minister seeking further information on how to achieve a solution, as well as an extension of time in which to comply. On Monday, February 12, he was called with the news that Mr. Simms had attended and issued an order that resulted in a closure of the plant. Mr. Tupper was angered and telephoned the Deputy Minister to express his strong feelings about the manner in which this has been handled. He testified that the Deputy Minister was surprised and indicated that he would look into the matter.

[140] As a result of the intervention of the Deputy Minister, Mr. Simms and Mr. Siggars were directed to attend at AFL and to administer a form of oral examination to provide temporary certifications to some of the employees, which would in turn allow sufficient time for a proper examinations to be administered.

[141] Mr. Siggars acknowledged that after the compliance order shut down the plant he received a call from both the Assistant Deputy Minister and Deputy Minister McNamara with instructions to find a solution that would allow the plant to reopen. He arrived at a solution that would involve an interview of the senior operators to determine their suitability for a temporary certification until they could

go through the regular certification process. This necessitated an extension of Mr. Simms's order which Mr. Simms indicated he was prepared to grant.

[142] Mr. Siggars conceded that he was "shocked" that they had shut down the plant. He felt that AFL could have found someone who was certified to work at the plant and have the other employees operate under their supervision, which is something that the statute allows for.

[143] Following the intervention of the Deputy Minister, Mr. Simms returned to the plant with Mr. Siggars on the next day, February 13, and participated in the ministration of a form of oral examination of some of the AFL crane operators. Conveyances were granted to extend the time in which the plant could operate using the operators so tested. It was understood that all of the intended AFL crane operators would be required to write the exam and obtain a proper certification to operate the four hoisting devices in question.

[144] I am satisfied that Mr. Simms was acting in good faith and within his discretion and the statutory authority provided to him when he attended AFL and

issued his order to comply in March of 2000. His approach was eminently reasonable.

[145] I also find that the concerns of the company were legitimately held, but that the actions they took in response to the order unintentionally complicated the achievement of resolution in an efficient and timely manner.

[146] With the benefit of hindsight, applications for certification should have been undertaken immediately. As subsequent testing demonstrated, there were a number of employees who successfully completed the examinations and obtained their certification. Unfortunately there was a delay of a year from March, 2000 to the spring of 2001 before that happened. In fact, as Mr. DeWare admitted, the manuals necessary to the preparation for the examinations were not even provided to the employees until after the shutdown in February, 2001.

[147] There were a number of reasons that led to the shutdown:

(i) The failure of the company to immediately, or at any time prior to shut down, seek traditional certification of at least some employees, which was not a prudent decision;

(ii) The failure of the company to hire an already certified crane operator under whose supervision the existing employees could have worked;

(iii) The application of an unpublished draft policy by the Board of Examiners, when they considered the employer's application for grandfathering under regulation 48 (1). The draft policy set as a precondition that applicants must have attempted and failed the examination before an exemption on the basis of experience would be considered. While this was not necessary, it is not an unreasonable approach from a regulator's perspective;

(iv) The company's submission for grandfathering included names of individuals who obviously would not have fallen within the intent of regulation 48. The reaction of departmental officials was nondiscriminatory. Rather than exercise the discretion to grant exemption to the most obviously

experienced, they chose to reject applications for all of the persons listed. While this was within the department's discretion, it was poorly motivated. It is apparent that the appeal to the Minister had no real hope of success because advisers to the Minister were against granting the exemption. It was simpler to refuse all than to agree to grant some selectively. It may also have been a means of showing disapproval of AFL's attempt to bypass the usual certification process;

(v) The company incorrectly assumed that because of the lengthy passage of time, and the number of extensions to operate without certified operators, that there was no perceived safety issue. It therefore expected that even in the event of a failed grandfathering application the department would provide some additional time to achieve compliance in some other manner;

(vi) The company underestimated the determination of Mr. Siggars and the Board to force the company to comply by having its employees certified in the usual manner;

(vii) While AFL retained Atlantic Crane in good faith and with appropriate safety concerns in mind, it overvalued the training offered to its employees by Bob Allen. He was not certified, was not teaching to the certification standard and offered no practical training. In the end a suitable resolution was achieved, but only with the direct intervention of the Deputy Minister of Labour, and the company yielding to the requirements to certify its employees in the normal manner.

Occupational Health and Safety Division

[148] The OHS Division applies and enforces the provisions of the **Occupational Health and Safety Act.** Section 2 of the OHSA provides the statutory foundation by which the actions of the employer, the employee and the Division are measured. It reads:

> Internal Responsibility System
>
> 2 The foundation of this Act is the Internal Responsibility System which
>
> (a) is based on the principle that

(i) employers, contractors, constructors, employees and self-employed persons at a workplace, and

(ii) the owner of a workplace, a supplier of goods or provider of an occupational health or safety service to a workplace or an architect or professional engineer, all of whom can affect the health and safety of persons at the workplace, share the responsibility for the health and safety of persons at the workplace

(b) assumes that the primary responsibility for creating and maintaining a safe and healthy workplace should be that of each of these parties, to the extent of each party's authority and ability to do so;

(c) includes a framework for participation, transfer of information and refusal of unsafe work, all of which are necessary for the parties to carry out their responsibilities pursuant to this Act and the regulations; and

(d) *is supplemented by the role of the Occupational Health and Safety Division of the Department of Labour, which is not to assume responsibility for creating and maintaining safe and healthy workplaces, but to establish and clarify the responsibilities of the parties under the law, to support them in carrying out their responsibilities and to intervene appropriately when those responsibilities are not carried out. 1996, c. 7, s. 2.* (emphasis added)

[149] The **Act** provides broad powers to inspect, gather information, seize, and issue orders for the purposes of gaining compliance. There is power to prosecute regulatory offences in a quasi criminal proceeding.

[150] In addition there is a panoply of internal policies and procedures intended to guide the regulators in the performance of their duties.

Crane Operator Certification Problem: Part 2

[151] On May 11, 2000, Occupational Health and Safety Division Inspector Alan Ross attended to conduct an inspection at AFL. He issued order 530277-02 directing that: "The employer shall ensure that hoists are operated by designated competent persons." An associated Order, 530277-06, required the employer to "... ensure that rigging is done by designated competent persons". These orders were to be complied with on or before June 11, 2000.

[152] On May 31, 2000, Marty Patriquin, Production Manager and JOHS Coordinator at AFL, wrote to Mr. Ross intending compliance with the order by indicating that the majority of the employees at the plant had years of experience as well as training from Atlantic Crane and Material Handling. This was not the information needed for compliance under the **OHSA**. Mr. Ross was looking for a list of the names of persons who would be "designated" as "competent operators".

[153] A meeting was set up on June 23, 2000 for Alan Ross and his regional manager, Dale Bennicke, to meet with Mr. Nickerson to discuss the requirement of the **OHSA.**

[154] The employer agreed to provide such designations by June 30.

[155] On June 26, 2000 Steve England, the Chairman of the Safety Office of the Cherubini group wrote a letter to Mr. Ross that was copied to the Deputy Minister of Labour, among others. He expressed his disappointment with the June 23rd meeting, citing the existence of compliance order S10202 issued by John Simms on March 28, 2000 as already addressing the issue of certification of crane operators. Mr. England expressed concern with the "harassment" on this issue and suggested that Mr. Ross contact head office in Halifax for "clarification".

[156] Mr. England confused the order issued by Mr. Simms with that of Mr. Ross and so took an aggressive position.

[157] In fact, Alan Ross issued the order under different legislation for different purposes. Some of the hoisting cranes in AFL were not subject to the **Stationary**

Engineers Act. He was not requiring that the operators be certified, only that those who were designated by the company as competent to operate the cranes be listed, and the names provided to him. This was explained to Mr. England in a letter from Mr. Ross dated June 27, 2000.

[158] Not satisfied, Mr. England, in a letter of June 27 again challenges and says that "it is our opinion that we have satisfied the Department of Labour requirements". He cited the training that the crane operators had, and that the list of those people had been submitted to the Public Safety Division, and the office of the Minister for the Department of Labour. He says that those names are the "designated competent persons".

[159] On June 29, Mr. Patriquin sent a letter to Mr. Ross that included the list of designated hoists operators by name. At that point the matter was considered to be closed.

[160] The circumstances surrounding the designation of competent operators, and the certification of same, is an excellent example of the communication problems that existed as between AFL and the Department of Labour.

[161] It is apparent by Mr. England's comments that he was unaware that these issues were being treated differently and for different purposes by different divisions of the Department. In his mind, they were essentially seeking the same information, and that the OHS Division was not kept informed by the SED. Even if it were established that the list of names provided to SED had been shown to Mr. Ross, it would still not have constituted compliance under the **OHSA.**

[162] The matter was easily resolvable, but the lack of trust between the employer and Mr. Ross continually caused AFL management to react aggressively, even in circumstances where the solutions were simple. In the context of all of the other problems that they were having at the plant it is understandable that they saw harassment everywhere. It was further exacerbated by what they saw as incompetence on the part of the Department of Labour inspectors. It does not however mean that Mr. Ross erred in issuing the order, or in how he handled the confusion that existed. He took an appropriate step in meeting with Mr. Bennicke and Mr. Nickerson to try to resolve it. There is no question that in copying his letter to the Deputy Minister, Mr. England's action would not be appreciated by Mr. Ross.

Inspections, Orders and Compliance Notices

[163] The **Occupational Health and Safety Act**, and regulations made thereunder exist to ensure a healthy workplace for those subject to its provisions.

[164] The **Act** sets out a series of precautions, responsibilities and duties for each of the employer and employee to meet to achieve this goal. *see,* sections 13-23, and especially ss. 13, 17 and 19.

[165] Section 12 authorizes the Minister to designate certain occupational health and safety officers to act as inspectors or chief inspectors under the **Act**.

[166] Section 47 gives a discretionary authority to officers to inspect, examine and collect information or materials for the purpose of ensuring compliance with the **Act**, and regulations made thereunder. Ensuing sections authorize a power to seize evidence in a worksite (s. 48); to enjoy the powers and protections of a peace officer (s. 49); to issue "stop orders" where there is unsafe equipment or

equipment that is substandard in use (s. 51); and to require tests, reports, or assessments (s. 52).

[167] A key statutory tool available for monitoring and addressing issues in the work place is the power to issue orders and to require compliance. The use of these powers by officers was a source of significant consternation to the management and owners of AFL. The relevant provisions are:

> Orders and consequences of orders
>
> 55 (1) An officer may give an order orally or in writing to a person for the carrying out of any matter or thing regulated, controlled or required by this Act or the regulations, and may require that the order be carried out within such time as the officer specifies.
>
> (2) Where an officer makes an oral order pursuant to subsection (1), the officer shall confirm the oral order in writing.
>
> (3) For greater certainty, an oral order is effective pursuant to this Act before it is confirmed in writing.
>
> (4) Where an officer makes an order pursuant to subsection (1) and finds that the matter or thing referred to therein is a source of danger or a hazard to the health or safety of a person at the workplace, the officer may order that
>
> > (a) any place, device, equipment, machine, material or thing not be used until the order is complied with;

(b) work at the workplace or any part of the workplace stop until the order to stop work is withdrawn or cancelled by an officer;

(c) the workplace or any part of the workplace be cleared of persons and isolated by barricades, fencing or any other means suitable to prevent access thereto until the danger or hazard is removed.

(5) Where an order is made pursuant to clause (4)(c), no employer or supervisor shall require or permit an employee to enter the workplace or part of the workplace that is the subject of the order except for the purpose of doing work that is necessary or required to remove the danger or the hazard and only where the employee is protected from the danger or the hazard.

(6) Where an officer issues an order pursuant to this Section, the officer may affix to the workplace or to any device, equipment, machine, material or thing a copy or notice of the order and no person except an officer shall remove the copy or notice unless authorized to do so by an officer. 1996, c. 7, s. 55.

Compliance notices and determination of compliance

56 (1) Where an officer makes an order pursuant to this Act or the regulations, unless the officer records in the order that compliance with the order was achieved before the officer left the workplace, the person against whom an order is made shall submit to the officer a compliance notice within the time specified in the order.

(2) Where a compliance notice is required pursuant to subsection (1), the officer shall specify in the order the time within which the person against whom the order is made shall submit the compliance notice to the officer.

(3) Notwithstanding the submission of a compliance notice, a person against whom an order is made achieves compliance with an order made pursuant to this

> Act or the regulations when an officer determines that compliance is achieved. 1996, c. 7, s. 56.

[168] The OHS Division, offered training with mentoring, and had a series of policies that were intended to be followed by its officers in an effort to achieve consistency in the application of these enforcement powers. The position taken by the Executive Director in his evidence is that neither the training advice, nor the policies could fetter the discretion of any officer to exercise their statutory powers, providing that the actions taken were authorized by the **Act** or regulations.

[169] There were division "policies" in place to guide the officers in the performance of their inspection duties under the **OHSA**. Those which are relevant to the plaintiff's argument include:

> 4.3 Compliance Strategy
>
> The purpose of the compliance strategy is to *guide* inspection and compliance activities of all our division health and Occupational Health and Safety officers under the N.S. Occupational Health and Safety Act in order to:
>
> - achieve consistency within the division
> - ensure fairness in administering the acts and regulations

- maximize effectiveness in promoting compliance
- economize on resources to achieve our goals

This policy deals with inspection reports, order forms, written orders, oral orders, Stop Work Orders and prosecutions.

The department recognizes that there are various techniques in achieving compliance. The division *favours* the following approaches, in order of preference:

a) Notice on Inspection
b) Compliance Orders
- Time Based - Forthwith - Stop Work
c) Prosecution

(emphasis added)

[170] The first approach favoured by the division, Notice on Inspection, is discussed in policy 4.6 which opens:

Where an officer notes a workplace deficiency where an Order is not warranted and which can be readily addressed through the IRS, Notice on Inspection *shall* be given (on the Inspection Report). The officer may follow up if it is deemed necessary. (emphasis added)

[171] Policy 4.7 sets out the divisional view as to how, and when, the second approach, "Compliance Orders", is to be employed. It includes the following:

The compliance order will be issued by the officer where:
- notification has not resulted in the correction of an identified problem or has failed to meet an agreed upon deadline
- there is a direct contravention to a regulation
- the offence is considered by the officer to be a flagrant violation of th act or regulations.

[172] AFL was issued 52 orders by DOL, 48 of which were required to be satisfied by compliance notices under section 56 of the **OHSA**. The remaining four were issued under the **Stationary Engineers Act.**

[173] In a pretrial application brought by the defendant in this matter, cited as *Cherubini Metal Works Ltd. v. Nova Scotia (Attorney General)* 2006 NSSC 239, Coughlan J. ruled at paragraph 8:

> Orders pursuant to the *Occupational Health and Safety Act*, S.N.S. 1996, c. 7 and the *Stationary Engineers Act*, R.S.N.S. 1989, c. 440 were issued to the plaintiff. The orders were subject to challenge by way of appeal or judicial review. Some of the orders were appealed. It is now not open to the plaintiff to attack the orders.

[174] The plaintiff acknowledges that it cannot now attack the validity of the orders, but submits that it is open to the court, as part of the overall assessment of defendant's actions, to consider whether the factual bases, and the motivations, for the issuance of the orders supports its position that the defendant engaged in tortious conduct against AFL. Plaintiff says that AFL was discriminated against by officers, particularly Alan Ross.

[175] The following is a chronology of the orders issued to AFL:

<u>1999</u>

03 Jun	3	(Ross)

<u>2000</u>

28 Mar	3	(Simms)
11 May	6	(Ross)
29 May	1	(Ross)
06 Jun	1	(Ross)
24 Aug	1	(Ross)
19 Dec	9	(Ross)

<u>2001</u>

12 Feb	1	(Simms)
06 Mar	16	(Walsh)
28 Mar	6	(Ross)
16 Jul	5	(Walsh)

[176] Only Mr. Simms' order of February 12, 2001 had the effect of a "Stop Work Order", although it was framed as a "Time Based/ Forthwith Order". The remaining ones were "Time Based", that is, they included a time by which compliance must be shown.

[177] Evidence led by the defendant shows that comparable industries in other parts of the province were subject to comparable inspection and compliance

actions in a comparable time frame. Alan Ross testified that the number of inspections increased in work places that, by the nature of the work performed, exhibited higher risks of worker injury. In particular, Mr. Ross was concerned that AFL was experiencing a number of injury accidents which attracted increased inspection activity starting in 2000.

[178] In the period March 30, 1999 to August 22, 2002, Maritime Steel Foundries Ltd. was issued 93 orders. RKO Steel Limited was issued 57 orders in the period June 30, 1999 to July 8, 2002. For the period February 24, 1999 to January 9, 2002 Marid Industries was subject to 46 orders. All three companies were engaged in facets of structural steel fabrication.

[179] The number of orders issued to AFL, then, is not a gauge by which the activities of the regulator at AFL can be measured.

[180] In the relevant time period, Mr. Ross issued 289 orders which I take to include the 27 that he issued to AFL. The evidence does not demonstrate, on the basis of the numbers of orders he issued to AFL as a percentage of his overall orders issued, that he was unfairly singling out AFL.

[181] If fault is to be found with the work of Mr. Ross, it is in his decisions to issue Orders rather than Notices on Inspection in circumstances that policy would clearly have favoured the Notice approach. This point is reinforced in the evidence of other officers which indicates that they were applying a substantially different and higher threshold before issuing orders. The approach they described is consistent with the policy. Cherubini's prior inspection history at its preexisting plants was also consistent with the policy and the practice of officers, other than Mr. Ross. It is evident that Mr. Ross did exercise his discretion in what appears to be an atypical manner.

[182] The plaintiff argues that Mr. Ross maintained a bias in favour of the union and against the employer. There is some evidence to substantiate this, but it is not overwhelming. A more reasonable conclusion is that he was officious and unchecked by his supervisors in his use of orders at AFL.

[183] A few examples stand out. His very first order, # 530071-01, was issued on June 3, 1999 and required that the employer "...ensure that the JOHSC meets and addresses its responsibilities under section 31 of the OH&S."

[184] At that point the company was still in startup having gone into production just over a week earlier. Mr. Ross noted in his Inspection Report that: " JOHSC formed but has not met yet. (Plant being restarted after closure.)"

[185] Having regard to the criteria in Policy 4.7 there was no reason to issue this as an order. At most, it should have resulted in a Notice of Inspection.

[186] On May 11, 2000, orders were issued by Mr. Ross that required the employer to ensure that the safe lifting capacity of rigging hardware be identified on the rigging hardware. This was a matter that had already been identified by the JOHS Committee and was being dealt with. Further it was evidenced in the Minutes of the Committee, which Mr. Ross had access to. Again his decision to issue an order was not consistent with Policy 4.7.

[187] On May 29, 2000 he issued an order requiring that the employer provide certain investigation reports. The employer says, and I accept, that had he asked for them he would have been provided them. Instead he issued an order, again in circumstances that Policy 4.7 would not have required.

[188] Similarly on August 24, 2000 he ordered the employer to provide copies of the most recent hoist inspection reports. He had already reviewed them and knew they were present. He only had to ask and he would have been provided copies. Instead he issued an order.

[189] The orders which the employer takes particular umbrage with were those issued by Mr. Ross on December 19, 2000. The circumstances are a good example of why the plaintiff believes that there was a conspiracy of DOL and the union to injure the company.

[190] As noted previously, Mr. Luedee unilaterally communicated alleged safety concerns to Mr. LeBlanc on November 30, 2000. He also alleged a failure to train union members of the JOHSC.

[191] The evidence shows that neither of Mr. LeBlanc, nor Mr. Ross inquired as to whether the concerns expressed had been brought to the attention of the employer as required by section 17 of the **OHSA**. In this they were also in breach of OHS

policy 3.2 which states: "The complainant *shall* be asked if the matter has been taken up with the J.H.S.C. supervisor or employer."

[192] On December 1, 2000 Mr. Ross sent an email to James LeBlanc in which he outlined his extensive and unilateral discussions with union JOHS Committee member Marty Davidson.

[193] Mr. LeBlanc directed Mr. Ross to inspect AFL. It is evident that news of Mr. Ross' impending inspection was leaked to the union, in contravention of Policy 1.1 which states that the inspection program should "Ensure that prior notice shall not be given to any client before a general inspection." Alan Ross advised Cal Luedee that he would be doing an "inspection in the near future", which was an inappropriate thing to do. i.e., giving advance notice of an inspection.

[194] Mr. Ross issued two orders directing the employer to provide training for JOHSC members, at company expense. Neither of these are requirements in the **OHSA** or the regulations. A s previously noted, this had already been offered to them, and the union meeting minutes of November 29 reflected this to be the case.

Mr. Ross would have known this if he asked the employer before issuing the order. The fact that he targeted this issue was obviously a direct response to Mr. Luedee's untruthful assertion to Mr. LeBlanc that such training was not being offered. At best, Mr. Ross failed to make reasonable inquiries to ensure the union complaint was justified and accurate. At worst, he already knew this to be the case and did it anyway. I accept the former as the correct explanation.

[195] Mr. Ross also issued four orders to post documents: the JOHSC minutes, the OHSA, the orders themselves which he was issuing, and regulations applicable to the workplace. These documents had always been posted in the past and, other than the December 19th orders themselves, were in place just before the inspection. The inference I have been asked to draw is that a unionized employee, with foreknowledge of the inspection, took down these documents thus creating a potential violation. In addition, the plaintiff complains that these orders were unnecessary and by policy and good practice should have been addressed by a Notice on Inspection. I agree with the plaintiff's position.

[196] Mr. Ross' reliance on orders, to the exclusion of Notices on Inspection, was a product of his inexperience, both in OHS and in this particular industry. From

1982 to 1998 he was a Public Health Inspector and operated under a different set of policies to enforce compliance. He had been an OHS officer for 8 months when he took over the AFL file. It was also a product of his inflexibility - to the point of single-mindedness in his approach.

[197] Some of his interventions did generate unnecessary, if presumptively valid orders. In his testimony, Mr. Ross explained that he did not use Notices on Inspection. He says that his practices were consistent with the training he received. If that is the case then his training was inconsistent with the understanding of other officers and with a plain reading of the Policies.

[198] I accept that Alan Ross is sincere in his belief that he was following proper procedure and that each order he issued had a basis in fact and in law. I am also of the view that he had no understanding of the function of a Notice, and an incomplete understanding of the use of an Order. Simply put, he believed that an Order was the default position to take when he wanted anything from the company or wanted them to address any concern he had, trivial or serious.

[199] Another complaint against Mr. Ross, and also Mr. Walsh (see Rigging Orders), *infra*, was the use of multiple orders where, in the opinion of AFL, a single order with multiple particulars would suffice. e.g. Orders 341136-01 through 341136-08, issued on March 6, 2001, directed compliance with eight different subsections of **Occupational Safety General Regulation** 80. This reflects the different perspectives of DOL and AFL as to the purpose and effect of the orders.

[200] For AFL the multiplicity of orders tainted the company reputation and made it appear "unsafe". They felt that if a single regulation was being addressed, notwithstanding that it had various subsections with varying requirements, then all issues could be wrapped up in one order. Requests to officers to do this were refused.

[201] The plaintiff contrasted Mr. Ross' treatment of AFL when he issued four separate orders to post on December 19, 2000, with orders in other job sites that joined postings into one order. Mr. Ross was pointed to several instances where he had used a single order to other companies to ensure the maintenance and posting of various documents such as JOSHC Minutes, orders, etc. On the one hand it

does demonstrate that he was being even handed in issuing posting orders, but on the other, it does reflect that he employed his discretion differently at AFL in this instance.

[202] I accept that generally the most effective mechanism to ensure clarity of the order, and the sufficiency of compliance, is to specify the item to be corrected and the regulatory basis for the direction. Merging even closely related concerns into one blurs the particulars and has the potential to create confusion. Having regard to the disputes that existed from time to time as between the DOL and AFL management, such a practice had an increased likelihood of problems. The decision of DOL officers to issue multiple orders was within their discretion and not unreasonable. It nevertheless is troubling that in some isolated instances there was a different treatment of AFL from that at other businesses. i.e., the posting orders.

Joint Evaluation

[203] Raymond O'Neil was the Acting Provincial Manager and Regional Manager for Central Region (NS) for OHS Division at the material times to this matter.

[204] Mr. O'Neil's first direct involvement with AFL came in late November or early December, 2000. James LeBlanc requested that he meet with Cal Luedee to discuss allegations of health and safety issues at AFL. He was aware that OHS inspectors seemed to be going into AFL "quite a bit". He saw the number of complaints from Cal Luedee to DOL, directly, as unusual. He was aware that there was "friction" between the employer and employees, and that "we [OHS] were caught in the middle". He and Mr. LeBlanc wanted the complaints to stop and so his goal was to narrow down the issues and ultimately put the onus for safety "on the workplace".

[205] The Internal Responsibility System checklist was something that Mr. O'Neil helped develop and, in his view, when the IRS was functioning properly it would ensure that safety concerns were resolved in the steps set out in Section 17 of the **Act**. Reporting would occur internally and resort to the OHS Division would only take place when the safety concern was not addressed at the earlier stages.

[206] It seems likely that the first time a Joint Evaluation was discussed among DOL staff occurred at the staff Christmas party during the first week of December, 2000 and that it was decided shortly thereafter that one was appropriate.

[207] The evidence satisfies me that Mr. O'Neil told Mr. Luedee of the intention to conduct a joint evaluation and that an outside consultant would be hired to assist. While Mr. O'Neil cannot recall doing this, Cal Luedee reported this information to the union meeting of January 9, 2001.

[208] On January 10, 2001, Alan Ross provided Mr. O'Neil with a report on his contacts with AFL.

[209] On the following day, Mr. LeBlanc responded to an inquiry from Deputy Minister McNamara about AFL in which Mr. LeBlanc said: " From waht [sic] I can see we are trying to ensure that the laws are being complied with while not to [sic] become the meat in the sandwich, as the union and the employer develop their working relationship."

[210] On January 15, 2001 a meeting was held in Springhill. Cal Luedee, Barry Cormier, Brian Gouthro, Aubrey Warren and Marty Davidson attended on behalf of the union. DOL officials in attendance were Ray O'Neil, Alan Ross and Dale Bennicke. The meeting was characterized by Mr. O'Neil as a response to Mr. Luedee's complaint of November 30, 2000.

[211] Mr. Ross recorded the following as discussion items in this meeting:

1. The inspection report and compliance orders issued to AFL on December 19, 2000;

2. That union and JOHSC members felt safety training was inadequate at AFL;

3. The union indicated that there were 18 accidents/incidents at AFL since April 2000. The number and nature of injuries suffered was of concern to the union;

4. Union members represented that crane operators received only two hours of classroom training during the summer of 2000. New employees were operating hoists without any formalized practical training;

5. Union members indicated that the receiving area crane had undergone make shift repairs and that poor maintenance was conducted;

6. Union members complained of a lack of maintenance personnel;

7. The employees felt intimidated by management because of a pressure to produce;

8. The safety program was not prepared in consultation with the members of the JOSH committee;

9. The JOSHC were not being provided with copies of DOL reports, orders, compliance notices, accident investigation reports.

10. The JOSHC was being told to determine fault in the accident and near miss investigations which led to disciplinary actions. Mr. Luedee was noted in particular as being quite upset with this approach.

11. A faulty foot pedal on shears was raised at the JOSHC prior to an accident.

[212] Mr. Luedee and union members expressed concern over the management approach to addressing health and safety issues, citing a lack of consultation with the JOSHC. They were predicting serious injuries if these issues were not resolved.

[213] Two commitments were made to the union: first, that DOL would engage an independent consultant to assess the qualifications of hoist operators at AFL; and second, that a Joint Evaluation would be conducted at AFL.

[214] After this meeting, Mr. O'Neil held the opinion that the IRS was not working at AFL, but that there was nothing brought forward to that time that he saw as a "real serious concern", otherwise he would have acted immediately. All were manageable under a properly functioning IRS.

[215] On January 31, 2001 Mr. O'Neil sent a memo to James LeBlanc recommending that "... we carry out a joint evaluation of the workplace in accordance with Section 2.0, Policy and Procedures Manual" and further that "... we [OHS] contract the services of a consulting company to evaluate the training program, if any, the company may have in place to train crane operators."

[216] In support of his recommendation he says:

> ... I see a pattern developing where health and safety concerns only get addressed when this office gets involved. Issues being raised by the United Steel Workers of America are issues, in most cases, [that] can be addressed through the health and safety committee. However, based on our meeting with two committee members on January 15, there is very little consultation with the committee. In particular, training of employees, finding fault in accident investigations, no consultation on safety program, terms of reference for JOHSC and the feeling they are being intimidated by management when it comes to addressing health and safety issues.

[217] The plaintiff raises the concern that the employer was neither advised of nor invited to participate in the Springhill meeting. I am not troubled by this - it is a legitimate exercise of discretion for DOL to meet individually with the employer, the employee or an interested third party. The goal is to ensure that safety issues

are brought forward and acted upon, and if meeting privately will encourage that, then it is a reasonable strategy for OHS to employ.

[218] I do, however, have serious concerns with the actions of the DOL in the process used to determine that a Joint Evaluation of AFL was appropriate. Once there is a decision to meet without one of the participants in the tripartite relationship, about issues that directly impact on that participant, then there is an onus on the DOL to:

> 1) access materials and resources available to them to satisfy themselves that the information they are being given is an accurate and fair representation of the situation;
>
> 2) ensure that the complainant fulfilled their responsibilities under the **Act,** and, in particular section 17, before involving OHSD;
>
> 3) select a proportional response to the information ultimately determined to be the basis of the safety concern.

[219] As will be seen, the information which Mr. O'Neil relied on in making his recommendation was seriously flawed. More importantly, the correct information was within the knowledge of his own division had he chosen to seek it out, or been alerted to it by Alan Ross.

[220] Mr. O'Neil's testimony focused on four factors that influenced him in directing that a Joint Evaluation be conducted:

1. Union complaints;
2. His review of the Ross Inspection reports;
3. The "tone" of the company's correspondence;
4. Cal Luedee and his style (the need to "get him out of [the OHS'] hair").

[221] I find that union representatives gave false or misleading information to the DOL personnel at the Springhill meeting and that Mr. Ross knew or ought to have known that some of the information was false or misleading.

[222] It was wrong for Mr. O'Neil to conclude that "...safety concerns only get addressed when this office gets involved." There was an extensive safety program

and training for employees that was mandatory. They were required to signify in writing that they had familiarized themselves with it.

[223] In the absence of a provincially approved training certification program for crane operators, AFL was proactive and hired Atlantic Crane to offer a course that was considerably more involved than the "two hours" suggested by the union representatives. There was on the job supervision and mentoring. Many of these operators were employed in the same capacity with DBC and were not trained or certified, yet they carried on without apparent regulator involvement. That the union was now complaining should have raised questions for DOL as to the motivation behind the complaint.

[224] Despite its' many problems, the JOSHC was functioning on many levels, including the identification of safety problems in the plant and the pursuit of appropriate remedies.

[225] The evidence shows that there was regular maintenance, of reasonable quality, by persons hired for that purpose. This information was known or ought to have been known by Mr. Ross. Again, in looking at the union pattern of

complaints, this was a way of trying to divert fault from its' members and onto the company, and unjustifiably so.

[226] There was pressure to improve production. The union wanted to control the time spent at work stations and did this by extending breaks. In October and November 2000 alone they filed 18 grievances over the issue of break times. There were allegations of sabotage to equipment which affected production. In other words, the "pressure" was not, from a company perspective, emanating from a "safety" issue, but as one of control of the production line.

[227] The requirement to find fault by the JOHSC was part of the Collective Agreement. It was a mechanism to assist the company to identify the reasons for accidents or "near misses" and to take appropriate action to correct them. The union did not want to honor the agreement that its' members could be disciplined where fault was attributed to them. Again the complaint of the union was aimed at undermining the Collective Agreement and using DOL to assist them.

[228] The union complained that the Safety Program Manual was supposed to be developed "in consultation" with them and was developed for Cherubini's other

sites, not AFL. However, this was a specious argument. Mr. Ross, in cross-examination acknowledged that much of the manual set out safe practices that were not site specific and could apply to AFL.

[229] Posting of orders, notices and reports, or supply of same to the JOSHC was never an issue in the plant, except in December 2000. That, as I have found, was as a result of the DOL's own error in giving the union advance notice of an impending inspection. Again, this was something that Mr. Ross would have known.

[230] All compliance orders were satisfied or under appeal.

[231] In a separate memo from Mr. O'Neil to Mr. LeBlanc, dated January 30, 2001, he states:

> I'm very concerned about the overall tone shown by this company in regards to their dealings with this office. It appears to be one of confrontation rather than any constructive approach to addressing health and safety concerns.

[232] He then cites comments from five different letters submitted by representatives of Cherubini to the Department of Labour in support of his

conclusion. He was taken through each in cross examination. Mr. O'Neil conceded that in fact the company had been complying with orders, but held on to the view that he didn't like the "tone" of the company correspondence, which he found to be "confrontational". He did not examine the context to see if the company had legitimate reasons to be upset. Even if they did not, a position I would not agree with, he had a responsibility under s. 2 (d) "to support" and "to intervene" appropriately which I believe includes a duty to be balanced and fair.

[233] DOL officials failed to ensure that the safety concerns being identified had been properly reported by the employees as required under Section 17 of the **OHSA**.

[234] In the result, an intrusive general inspection was ordered.

[235] Mr. O'Neil stated that he was motivated in part by what he perceived to be resistance by AFL to DOL oversight. He acknowledges that he made no independent inquiry to determine whether the company might have legitimate concerns about DOL activities, nor did he make an independent inquiry about the accuracy of the employee complaints.

[236] Mr. O'Neil had previously signaled that Mr. Ross would lead the joint evaluation. When the company complained, which led to Mr. Ross's removal from that position, Mr. O'Neil disagreed. He felt that to accede to the company wishes would put a chill on the local inspector who would normally be expected to lead such an inspection.

[237] Again it did not occur to Mr. O'Neil that the company might have legitimate concerns with Mr. Ross leading the evaluation. There was a real potential for an appearance of bias on Mr. Ross' part since the company questioned his competence in his inspection activities to that time. He lacked experience with steel fabrication plants and he had no prior experience with joint evaluations. Instead of weighing these factors, Mr. O'Neil obviously interpreted the company's stance as another example of their resistance to oversight.

[238] Mr. O'Neil says that he knew Mr. Luedee and his style and so he saw this as the "best approach" to remove Mr. Luedee and the union from the process. A thorough evaluation had the potential to put an end to the union's credibility in advancing complaints if there were few or no issues. In the end, Mr. O'Neil takes

the position that he made a "judgement call" on the best way to get to the bottom of the problem at AFL. Ironically he may have been right, but he relied on a flawed and factually inaccurate rationale to justify it.

[239] The Divisional Policy 2.0 says that Joint Evaluations are designed "... to permit a site specific, comprehensive review of a client's compliance with the Act, Regulations and applicable Codes of Practice."

[240] The objective is: "... to conduct an in-depth review of an establishment in relation to occupational health and safety programs and their adequacy and to ensure that the internal responsibility system is operating satisfactorily.

[241] The policy is described as "under review" and that "modification of the process" was being considered. It contemplates that the OHSD inspectors, and representatives of the employer and employees would jointly participate in the physical inspection of the plant.

[242] There is a flow chart accompanying the policy that suggests that the employer had the right to refuse such an evaluation. It is clear that neither of Mr.

O'Neil or Mr. LeBlanc considered such a possibility. It is an unusual provision, not reflected in the text of the policy. In the flow chart, a refusal by the employer results in further inspection activities. There was no bar in the legislation to an inspection being conducted by more than one person, and so whether it was characterized as a "Joint Evaluation" or a general inspection, the practical outcome to the employer would be the same.

[243] David Walsh was appointed as the lead officer for the conduct of the Joint Evaluation of AFL. At that point he had been with Occupational Health and Safety Division for approximately 13 years as an officer, and also served as a training officer with the Department of Labour.

[244] Mr. Walsh was first approached by Ray O'Neil in relation to undertaking this task. He prepared by reviewing the departmental file. He says that he was not aware of the difficulties existing as between the company and the union, nor what AFL's safety record was. The objective was to complete a "top to bottom inspection" of the physical plant and of the safety programs.

[245] The evaluation was conducted over two days. On the third day there was a debriefing and orders were prepared. His report, dated March 6, 2001, identified those participating in the evaluation as Alan Ross, Shelley Gray, and Ray O'Neill from the DOL, Steve England and Bob Power from Cherubini, and Brian Wells from AFL. The report covers 13 topics outlining a variety of concerns, some minor and some significant. Sixteen compliance orders were issued to AFL as result. Mr. Walsh acknowledged that Mr. England was taken aback at the number of orders issued, but none of the orders were appealed by AFL.

[246] Orders 1 through 8 all related to rigging issues and were issued pursuant to regulation 80 of the **Occupational Safety General Regulations**. Mr. England requested that these be combined into one order but Mr. Walsh refused. He was of the view that it was necessary to issue separate orders for each item of concern in order to enhance the opportunity for enforcement should AFL fail to comply with any or all of the directions. This was consistent with Mr. Walsh's view that he was "duty bound to enforce rigging regulations".

[247] In consequence of concerns with respect to rigging practices, Mr. Walsh sought out an opinion from someone with expertise in rigging practices. That person turned out to be David Campbell. His report is dealt with separately.

[248] The compliance orders issued are presumptively valid. The accompanying inspection report number 341136 provides particulars giving rise to the compliance orders issued. I am satisfied that the orders issued fell within the discretion that the statutory regime provides to an OHS officer.

[249] In addition, I note that, notwithstanding the number of orders issued, Mr. Walsh exercised discretion to the benefit of AFL. The most significant example related to a determination that there were defective brakes on the travel motor of a new overhead 6 ton crane. This created what Mr. Walsh described as a "scary situation". Mr. England provided information to indicate that the problem had been brought to the attention of the JOHSC and that a temporary fix had not cured the problem. It was within Mr. Walsh's authority to issue a Stop Work Order, which Mr. England pleaded that he not do. Mr. Walsh indicated that he would make it a "Notice Item" if it was serviced right away and in the interim was locked out of service. The employer brought a technician from Dartmouth who repaired it

right away. In the result it was unnecessary to issue an order. Mr. Walsh's conduct also stands in contrast to the practice of Mr. Ross to issue orders as a first step approach to concerns that he observed in AFL workplace.

Rigging Orders

[250] The eight compliance orders issued under Regulation 80 of the **Occupational Safety General Regulations**, and which pertained to rigging issues in the plant, included requirements that the company, in consultation with the JOHS Committee develop plans to ensure that:

1. Rigging equipment met manufacturer specifications;

2. If manufacturer specifications were not available, then to ensure that the rigging hardware was certified by an engineer;

3. Regular inspections to discover defects were conducted;

4. Follow up actions were taken to correct defects where identified;

5. Defective equipment was removed from service;

6. A record of inspections and repair to rigging equipment was maintained;

7. Adequate training was in place for persons operating rigging equipment;

> 8. A competent person was in place to see that loads were secured properly before a hoisting operation.

[251] A Management Plan, as required by the March 6 orders, was submitted and those compliance orders were ultimately released.

[252] On March 28, 2001 a serious injury accident took place. An employee named Mark Blacklock was hoisting a compound beam when it fell, causing injury to his leg. An inspection took place and six Compliance Orders were issued by Alan Ross that addressed the equipment in use at the time of the accident, and similar equipment in the plant.

[253] David Campbell was retained by DOL to evaluate rigging practices at AFL. His report was vetted by DOL staff. It lead to the issuance of an Investigation Report and Compliance Orders dated July 16, 2001.

[254] When the July orders were served on the Gasparettos they were infuriated, as they purported to apply a rigging practice to the AFL plant that was not going to be required at any other place, in particular their competitors. They, quite

understandably, believed that if the rigging practices being forced on AFL were intended to correct dangerous practices then they should be applied universally in the industry so as to ensure not only common standards of safety, but equality in the impact that the new practices would have on rates of production.

[255] The departmental response is that Compliance Orders are site specific and cannot be made to apply generally to plants that have not been subject to inspection. If there was an industry wide practice that needed to be corrected, then that would have to be addressed either on individual complaints and inspections or with an industry wide practice directive.

[256] The Gasparettos also took issue with certain of Mr. Walsh's proposed rigging practices as not being feasible. e.g. the universal requirement for a 2-point pick up, when there are situations where a single point pick up must be used.

[257] AFL filed an appeal against the orders, but they were dismissed as having been filed after the expiry of the statutory limitation period. The orders were never given effect in that workplace.

[258] The evidence is that these standards were never imposed on the industry, no safety bulletins were issued, and that some of these practices are still in use without departmental interference.

OHSA Prosecution

[259] Mark Blacklock suffered his workplace injury as a result of his incorrect use of a clamp in rigging product that he was working on. An investigation was completed by Alan Ross who submitted his recommendation to the Director that AFL be prosecuted for **OHSA** violations that he felt were indicated by the investigation.

[260] The Director approved the file for referral to prosecution. An Information was laid naming AFL as being accused of five violations under section 74 of the **Act**. The allegations were based on various purported safety and training deficiencies.

[261] The charges against AFL were dismissed after trial in Provincial Court.

[262] Since the establishment of the Public Prosecution Service in this province, it is the responsibility of the Crown Attorney to determine whether to continue or to terminate a criminal or quasi criminal prosecution. That decision is made on an assessment of the available evidence and the policy in place from time to time setting out the threshold test for the determination. The investigating agency, in this case the DOL, does not make that decision. As such, the decision to prosecute is not a basis on which to complain against the defendant, except where there is evidence to suggest that the motivation was improper.

[263] AFL adduced evidence that satisfied the trial judge that it had exercised due diligence in the provision of safety training, supervision, and facilities necessary to demonstrate compliance with the laws in issue in that trial.

[264] I have been referred by plaintiff to the following passages of the decision, reported at *R. v. Amherst Fabricators Ltd. [2003*] N.S.J. 280:

> 9 ... If the people using the equipment, the people expected to exercise safety, think it's all a pile of bologna and an inconvenience and slowing down their production, or just something they never did before and don't want to start now, aren't reporting near misses, aren't wearing their hard hats and safety glasses and are telling the management at JOHS meetings that they are not going to comply and have no intention to comply, those are circumstances that are beyond the control of the accused, which is the company in this case.

[265] In reading the entire context of this quote, the trial judge did not find these allegations to be fact, as it was unnecessary to his decision. But I agree, and have heard evidence in this trial that would support the conclusion that some employees had exactly that attitude toward compliance with company safety policies and procedures.

[266] At paragraph 12, the trial judge suggested that "... maybe the company was ahead of its time" in the creation and implementation of safety protocols. Again, there is some evidence before me that supports such an observation.

[267] I have also been pointed to the following comment of the trial judge, which summed up his assessment of the suggested insufficiency of employer provided training:

> 31 The crown offered no credible evidence, that I find credible that that training wasn't provided. Sorry, I have to come back to Mr. Blacklock again, he said he got no training, he did get training, if his signature is worth anything. The training was both from outside sources, the crane operator training, the supervision was from the foreman and the safety supervisors such as Mr. England, the instruction came from booklets and orientation courses. We heard evidence that those orientation courses were given to all people hired at the plant whether they had twenty years experience or no experience but the amount of it varied depending on that experience and we probably had men being hired here

> who'd been at Robb's and Dominion Bridge who probably could have taught their instructors a few things and as I say were necessary in the circumstances. The employer must take precautions reasonable in the circumstances to provide such information, instruction, training, supervision and facilities as were necessary and part of that was the training the employee already had. They took him out, they watched him do his thing and they said here try this, if he could do it and do it consistently, they moved on.
>
> If he couldn't, then they trained him and as I said earlier, they were leaders in their field it would appear, if Mr. Gasperrato is to believed, and I see no reason not to believe him, in establishing training facilities.

[268] The evidence before me supports the factual conclusions of the trial judge that the company was committed to ensuring safety in AFL, and provided broad based training to employees as described above.

[269] In my view, the fact of the prosecution is only further evidence that the DOL was aggressively pursuing options provided to them by statute. This was done in the context of a troubled workplace where they believed safety was in issue. The Blacklock accident, occurring in such close proximity to the Joint Evaluation was simply an extension of the DOL's investigative and enforcement efforts. There is no evidence to suggest it was motivated by bad faith or malice. In fact, a Crown Attorney obviously agreed with the internal assessment of DOL and undertook the prosecution independently of the DOL views. The acquittal of the accused does not undermine those decisions.

The Company

[270] Danillo Gasparetto gave evidence that as early as 2000, he and his brother, Renato, were losing hope that the plant could be made profitable. Poor workmanship, union harassment and poor productivity were all cited by Mr. Gasparetto as factors contributing to the plant's problems. Profit margins were "very, very low" and the company was losing money. The number of Compliance Orders being issued to the plant (24 by December 2000) were of particular concern. There was a potential that both AFL and the Cherubini Group of Companies, by implication, would be seen as "unsafe" and that it would negatively impact on their whole operation, not just AFL.

[271] Union and management officials met on December 1, 2000 in an effort to resolve some of the differences. Derek Nickerson and Renato Gasparetto were present for the company. Mr. Nickerson recorded that union concerns included the use of a two-minute buzzer, low morale, and threats of intimidation made by the company.

[272] Management expressed concerns over problems with the seniority classifications, JOSHC members who were too concerned about "ratting on their brothers"; and the number of grievances being filed.

[273] Renato Gasparetto expressed his concern that the employees were not devoted to working there or working to make the company succeed. He is quoted as saying that "the union needs to realize that we are here to work together and that everyone needs to carry their own weight *or the company will not last very much longer*." He added that except for the previous two weeks, the company had not made any money. He offered that the union could hire an accountant of their choice to check the books at the company's expense.

[274] During this same time in December 2000, the Gasparetto brothers were actively discussing the shut down of the plant, although they did not communicate it to anyone at that time. The reasons cited by Danillo Gasparetto included the lack of financial success - AFL suffered a loss of $467,058 by that time - a lack of optimism that things would improve at the plant, and the view that it was "not worth the trouble." At that point, the brothers' focus was on the problems with the employees, not DOL. That is where the real threat to the viability of the plant lay.

[275] The initial financial losses of AFL were expected and part of the business plan. The potential to mitigate the losses was present since AFL's role in Cherubini was to supplement the existing facilities. AFL was dependent for its' work on assignments coming from the Dartmouth offices. The problem was that the unacceptable quantity and quality of work being produced, together with the other problems in the plant, generated a loss of confidence in AFL's ability to do the work profitably, and so there was reluctance to allocate work to AFL.

[276] The Gasparettos decided that Cherubini needed another work site to replace AFL. They began a search for lands in late January 2001.

[277] On February 12, 2001 Mr. Simms' order shut down the plant for a day as a result of the problem with certification of crane operators.

[278] By the end of February, Cherubini completed its purchase of lands on Pleasant Street, in Dartmouth, on which to establish a new facility that would replace the AFL plant. Some work was assigned to the new site very shortly thereafter.

[279] The Joint Evaluation conducted on March 5 and 6, 2001, was, in the words of Danillo Gasparetto "....another nail in the coffin". The company could not understand why they had been singled out for this.

[280] Following the Joint Evaluation, the Gasparettos' emotions were "running high". In the next couple of weeks they decided that no more work would be assigned to Amherst.

[281] Notwithstanding this decision, they yielded to the entreaties of Bill Casey, the then Member of Parliament for the constituency in which AFL was located. The Gasparettos had great respect for Mr. Casey. He asked to convene a meeting with the union and the employer to see if there was a way to salvage the situation. That meeting took place on Saturday March 31, 2001. Mr. Luedee was excluded from participating in the meeting.

[282] At the end of the meeting the Gasparettos undertook to transfer 6 weeks worth of work from Dartmouth to AFL to provide an opportunity to the workers to demonstrate that the plant could function effectively. In addition, they wanted a

meeting with Barry Cormier at the first of the next week to address the many outstanding grievances. When Mr. Cormier balked because he had spent $2,000 on travel plans the company offered to pay that for him so that he could be available to meet, and not lose the money.

[283] Renato Gasparetto was optimistic that AFL would now work. Danilo did not share that optimism.

[284] The Gasparettos were not aware when they made these commitments that on Thursday, March 29, Cal Luedee swore out a complaint against the company under the **Trade Union Act**, R.S.N.S. 1989, c. 475 s.1, alleging interference with the administration of the union, discriminatory practices and intimidation of the union membership. The complaint was filed with the Nova Scotia Labour Relations Board on the following day (Friday) but not served on the company until the following Tuesday, April 2.

[285] The commitments made at the March 31 meeting were honored by the company, including the payment of $2,000 to Mr. Cormier. It was the last work

that AFL performed. The Gasparettos had had enough of what they saw as the union duplicity.

[286] On April 5 and 8, articles appeared in the media which cited the number of compliance orders issued at AFL, and identifying it with Cherubini. Mr. Luedee was quoted, and was likely the source for the stories. Follow up interviews with provincial politicians included one who described AFL as a “dangerous company.” It was precisely the concern that the Gasparettos identified a few months earlier. The evidence satisfies me that this type of publicity would negatively impact on the ability of Cherubini to attract work.

[287] Then Minister of Labour David Morse, was quoted in one of these articles describing the company as “overzealous” in its approach to the government about its’ regulatory actions.

[288] In the months to come, the company contended with the “Rigging Orders” (July 16, 2001), that came out of the Joint Evaluation. There was concern that their application would put the Cherubini Group at a competitive disadvantage if enforced only as against them.

[289] In addition, AFL successfully defended the allegations made in Provincial Court under the **OHSA.**

[290] These events, while seen as continuing and unjustified harassment of the company, were unrelated to the decision to shut down AFL. Cherubini had decided in December 2000 that AFL had no future and acted on that belief in quickly acquiring a new site. The decision to shut down AFL, often discussed, was effectively made in February, 2001. It was sealed the day the **Trade Union Act** complaint was served - April 2, 2001.

[291] The ambivalence shown by continuing operations into the early part of 2001 was a reflection of Renato Gasparetto's clear desire to see AFL succeed. Notwithstanding his hope for a last minute change of course, it was necessary for the Gasparettos, acting as prudent business people, to make alternate arrangements. They did not reasonably expect AFL to succeed.

[292] In 2001, AFL suffered a further net loss of $403,764.

[293] The Pleasant Street location opened shortly after its' purchase in February 2001. In 2002 and 2003 improvements were made to the land and in 2004-2005 a new 55,000 square foot building was erected. That facility went into production in September 2005.

[294] While there were differences between the Amherst and Dartmouth facilities, I conclude that had Cherubini been successful in operating the AFL plant on its business model, the plant would have continued. The facility was an attractive one, with good transportation links and the company had invested substantial sums of money in it. It was in Cherubini's interests to see it succeed.

[295] The catalyst to acquire the Pleasant Street site was the decision that AFL was "not worth the trouble" for the return it offered under the then existing labour conditions. Through **Freedom of Information and Protection of Privacy Act** S.N.S. 1993 c. 5, applications made after the plant closed, and through this litigation, the Gasparettos learned of the unilateral communications that had been going on as between the union and officials of the DOL throughout.

[296] They were surprised to learn of the “Springhill Meeting” and the role the union played in getting DOL to launch the Joint Evaluation. Danilo Gasparetto characterized the failure of the DOL to inform them of the meeting, or of the allegations made against their company as “outrageous”. It was then that they concluded that the DOL had acted improperly and that their actions, when seen in concert with those of the union, contributed to the failure of the plant.

ISSUES

[297] Is the defendant liable to the plaintiff for harm caused by the defendant’s alleged commission of one or more of the following torts:

1. International Interference with Economic Relations

2. Misfeasance in Public Office

3. Conspiracy

4. Negligence

ANALYSIS

Intentional Interference With Economic Relations

[298] In the case of *Reach M.D. Inc. v. Pharmaceutical Manufacturers Assn. Of Canada* [2003] O.J. 2062 (OCA) Laskin J.A., writing on behalf of the court, set out the basic requirements that a plaintiff must establish to attach liability to a defendant when asserting the commission of the tort of intentional interference with economic relations:

> 44 Reach [the plaintiff] ... must show that [the defendant's actions] amounted to the tort of intentional interference with economic relations. To establish this tort, Reach must prove three elements:
>
> I) PMAC [the defendant] intended to injure Reach;
>
> ii) PMAC interfered with Reach's business by illegal or unlawful means; and
>
> iii) As a result of the interference Reach suffered economic loss.
>
> see, *Lineal Group Inc. v. Atlantis Canadian Distributors Inc*. (1998), 42 O.R. (3d) 157 (C.A.).

Intent to Injure

[299] What constitutes the intent necessary to the proof of this tort has not been entirely resolved. The fundamental parameters are generally known and accepted.

[300] Laskin J.A. wrote in *Reach* that:

> 46 To satisfy the first element, Reach need not prove that PMAC's predominant purpose was to injure it. This first element of the tort will be met as long as PMAC's unlawful act was in some measure directed against Reach. That is so even if - as PMAC claims - its predominant purpose was to advance its own interest and those of its members. In short, "The defendant's manoeuvre must have been targeted against the plaintiff, although its predominant purpose might well have been to advance his own interests thereby rather than to injure the plaintiff". *see,* John G. Fleming, *The Law of Torts*, 9th ed., (1998) at p. 769.

[301] In *Daishowa Inc. v. Friends of the Lubicon et al.,* [1996] O.J. 152 (Ontario Court (General Division) Divisional Court), Corbett J. , writing on behalf of the court, stated:

> 63 It is difficult to distinguish the element of the requisite intention in respect of the particular tort alleged. The words "intention" and "purpose" are both used. "Ultimate" and "predominant" are used to describe purpose. Nonetheless, "motive" must be distinguished from either "intention" or "purpose".

> 64 Motive cannot justify an otherwise unlawful act or an otherwise tortious act. The morality of the goal cannot sanction unlawful means.... Intention has both subjective and objective elements.

> 80 ... The question then becomes to what extent is the ultimate or overall intention, or goal, or purpose, pertinent in respect of the intentions with which the

> acts were undertaken. The answer to this question is the same as determining whether there is sufficient justification for interference with economic relations.
>
> 81 ... The ultimate moral goal cannot justify an otherwise illegal act in the absence of some duty to interfere.

[302] The Nova Scotia Supreme Court, Appeal Division, addressed the evidence necessary to establish the requisite intent in *Cheticamp Fisheries Co-op Ltd. v. Canada,* [1995] N.S.J. 127 (leave to appeal to S.C.C. refused October 11, 1995). In that case, fishermen and fish brokers brought an action against the Department of Fisheries and Oceans (Canada) seeking damages as a result of allegedly unlawfully imposed dockside monitoring fees. The court held, per the reasons of Chipman J. A., that:

> 42... What the case law requires is an intention to cause the damage. Mere knowledge of D.F.O. officials that their actions were unlawful or recklessness as to whether or not they were unlawful is not, in itself, sufficient evidence of intention to do harm. I have already referred to the fact that the purpose or intention of inflicting injury is an essential element of the tort. The courts have stopped short of substituting for an intention to cause damage to the plaintiff a mere foreseeability that such damage may result from the unlawful conduct. A constructive intent to injure or foreseeable injury may have a place in the tort of conspiracy but not in my opinion in the tort of interference with economic relations. *See Canada Cement LaFarge v. B. C. Lightweight Aggregate Ltd. et al* (1983), 145 D.L.R. (3d) 385 at 398 - 9 (S.C.C.), Fleming, *The Law of Torts,* 7th Edition, (1987), p. 663, note 45, p. 665 especially note 59. I think that recklessness is more akin to foreseeability than it is to intention. If any lesser standard of intention were required, it still seems clear that the offending conduct must be "directed at" the plaintiff.

> 43 I do not find in the cases any suggestion that the ingredient of intention to injure can be found to exist merely because the defendant knew the conduct at issue was unlawful or was reckless as to whether or not it was.

[303] This view continues to be adopted as being a correct statement of the law by many courts in Canada. *see, Pembina County Water Resource District v. Manitoba* 2008 FC 1390, at paragraph 25; *Soost v. Merrill Lynch Canada Inc.* 2009 ABQB 591, at paragraphs 145-146; *Harbour Remediation & Transfer Inc. v. Toronto (City)*. 2005 O.J. 4687, at paragraph 81.

[304] The plaintiff acknowledges that the *Cheticamp* case confirms that proof of recklessness is not sufficient to establish the requisite intent, as it shows only an objective knowledge rather than the subjective intention. The plaintiff argues though that "willful blindness" is sufficient to satisfy the intent requirement.

[305] In light of the *Cheticamp* decision, the question posed by the plaintiff in this case becomes whether the defendant, irrespective of whether it knew its actions to be unlawful, can be held to have intended to injure when it ought to have known that injury would result to the plaintiff, but was wilfully blind to that fact. In support of its' argument the plaintiff relies on the decision of the Newfoundland Supreme Court in *American Reserve Energy Corporation v. McDorman*, [1999]

N.J. 198. The court had for its' consideration the intention element for the commission of a conspiracy tort. Adams J. stated at paragraph 191:

> 191 McDorman testified that the transfer was done to protect the permits. He claimed that he was only acting in the best interests of the shareholders of SREL and following their instructions. While this has an element of truth in it, McDorman was nonetheless wilfully blind to the injury likely to be caused to the plaintiff. He knew that the only person who could possibly be negatively effected by the transfer was American Reserve. He knew that injury was likely to result to the plaintiff and it did. He knew at the time that the promissory note evidencing the American Reserve loan was in default and that it was not likely to be repaid. He knew that the Transfer rendered American Reserve's security valueless and put the Permits beyond its reach. As a result, the plaintiff was deprived of its security and suffered a decline in its underlying value as a result of the drop in oil prices from January, 1997 to the date of trial.

[306] The concept of willful blindness has been regularly considered in the context of criminal cases. Plaintiff's counsel have referred me to the following description as set out in the case of *R. v. Rashidi-Alavije,* [2007] O.J. 4005 (C.A.) where, at paragraph 19, the court upheld the following passage taken from a jury charge:

> There are two ways the Crown may prove knowledge. Knowledge may be proved that there was either actual knowledge of the illegal substance or what is called "wilful blindness" concerning the existence of the substance.
>
> What is "wilful blindness" in this context? Where a person has become aware of the need for some inquiry about whether there was a prohibited drug in the suitcase or the item, in this case a suitcase, but declines to make the inquiry because he does not wish to know the truth, or would prefer to remain ignorant, in

> other words, is "wilfully blind" to the facts, the law still holds that person criminally responsible, as if he had actual knowledge. Wilful blindness is the state of mind of someone who is aware of the need to make an inquiry and deliberately fails to do so. It is imputed knowledge.
>
> However, mere negligence or recklessness is not enough. *Wilful blindness is a higher standard than either negligence or recklessness*. The person must be aware of the need to make an inquiry about whether prohibited drugs were concealed in the suitcase, but decided not to because they did not wish to know the truth and preferred to remain ignorant. You may ask: "Did the accused shut his eyes because he knew or strongly suspected that asking would fix him with knowledge?" Wilful blindness is the state of mind of someone who is well aware of the need to make an inquiry and then deliberately fails to do so because they do not want to know the truth. They prefer to remain ignorant. As I stated a minute ago, wilful blindness is equivalent to actual knowledge; it is imputed knowledge.
>
> [emphasis added]

[307] I conclude that wilful blindness is not a sufficient basis upon which to find that the defendant had an intent to injure which was directed at the plaintiff. The decision in *Cheticamp* in paragraph 43, set out above, holds that even if the defendant knew their actions were unlawful, that would not be a sufficient basis to find an “intention” to injure. Further, it is not sufficient that the resulting injury was foreseeable.

[308] Willful blindness as to whether or not injury could occur as result of the defendant’s actions may indeed be closer to the requisite intent than recklessness, but nevertheless, in my opinion connotes foreseeability, which the court in

Cheticamp specifically identified as having a place in conspiracy, but not in the tort of intentional interference with economic relations.

[309] Willful blindness speaks to the actor's state of knowledge, not necessarily to their intention. So, for example, the actor may be reckless or willfully blind as to the fact that injury could occur, yet not "intend to direct" its actions to cause that result.

[310] The rationale behind a stricter threshold for finding the requisite intent was addressed in *Correia v. Canac Kitchens* 2008 ONCA 506:

> [100] The elements of the tort of causing loss by unlawful means are: (1) wrongful interference by the defendant with the actions of a third party in which the plaintiff has an economic interest; (2) an intention by the defendant to cause loss to the plaintiff: *see OBG* at para. 47 (Hoffman L.). Again, the intentionality of the defendant's conduct is critical: it is not enough that the loss was a foreseeable consequence of the defendant's conduct; to be actionable under this tort, the loss must have been the intended result. Furthermore, intentional conduct that causes loss but is not unlawful, is not actionable. That is considered permissible competitive commercial behaviour.
>
> [101] We note that the requirement for intentionality may be stricter for these economic torts than for the tort of intentional infliction of mental distress, where, at least when a person is accused of criminal conduct, the foreseeability of the inevitable consequences of reckless conduct can amount to intent. The difference of approach is justified in this case. The two economic torts are strictly limited in their purpose and effect in the commercial world, where much competitive activity is not only legal but is encouraged as part of competitive behaviour that benefits the economy.

[311] I acknowledge that this rationale has less relevance where the defendant’s actions were not commercially motivated. It is open to debate as to whether a different threshold may be warranted for governmental actors, but that question does not need to be answered on the facts of the case at bar.

[312] The courts, to this point, have maintained a consistent view that the loss must be the intended result and that anything less is insufficient to satisfy this tort. It is a clear and easily applied standard, and one that I subscribe to.

Illegal or Unlawful Means

[313] As to what constitutes “illegal or unlawful means” within the context of the second element of the tort, the court in *Reach* said:

> 49 The case law reflects two different views of "illegal or unlawful means", one narrow, the other broad. The narrow view confines illegal or unlawful means to an act prohibited by law or by statute. ...
>
> 50 The broader view, however, extends illegal or unlawful means to an act the defendant "is not at liberty to commit" - in other words, an act without legal justification. Lord Denning espoused this broader view in *Torquay Hotel Co. Ltd. v. Cousins*, [1969] 1 All E.R. 522 at 530 (C.A.):

> I must say a word about unlawful means, because that brings in another principle. I have always understood that if one person deliberately interferes with the trade or business of another, and does so by unlawful means, that is, by an act which he is not at liberty to commit, then he is acting unlawfully, even though he does not procure or induce any actual breach of contract. If the means are unlawful, that is enough.

...

> 52 I think that the trial judge was right to take a broader view of illegal or unlawful means. It is, however, unnecessary to decide the outer limits of the principle in *Torquay Hotel.* Unlawful means at least include what occurred here: the Committee made a ruling that it was not authorized to make. Its ruling was beyond its powers. I see no policy reasons for taking a narrower view of unlawful means. Indeed, to do so would preclude redress against organizations like PMAC and others for any number of unauthorized acts that on a common sense view would be considered unlawful, but nonetheless, were not prohibited by law or by statute.

[314] The “broader view” described in *Reach* and set out in *Torquay Hotel*, was adopted in Nova Scotia in the case of *Spicer and Gaetz v. Volkswagen Canada Ltd.*(1978), 91 D.L.R. (3d) 42 (N.S.S.C. App. Div.) At paragraphs 48 and 49.

[315] The “outer limits” of “unlawful means” was considered by the Ontario Court of Appeal in *Drouillard v. Cogeco Cable Inc*. 2007 ONCA 322. The circumstances of that case, and the view of the court, are germane to the argument that the plaintiff in this case makes. Rouleau J.A., writing for the court held:

21 In my view, on the facts of this case, the trial judge erred in concluding that the breach by Cogeco of what appears to be an unwritten internal policy amounts to an unlawful act. Nothing in the record suggests that either Cogeco or its employees were "not at liberty" to act contrary to the company's internal policy or that Mastec or Drouillard had relied on this policy such that they could require that Cogeco respect it.

22 The situation in the present case is quite different from the facts of *Reach*. In *Reach*, the tortfeasor, the Pharmaceutical Manufacturers Association of Canada (the "PMAC") was a voluntary trade association whose powers were set by its membership. The PMAC had a written Code of Marketing Practices (the "Code") which the association administered through one of its committees. The committee made a ruling against Reach M.D. Inc., one of the association's members, which it had no power to make according to the Code. Laskin J.A. held that the PMAC had not been "at liberty to commit" the act because "the Committee acted beyond its jurisdiction" in making a ruling which it "was not authorized to make. Its ruling was beyond its powers": *Reach* at paras. 43, 52, and 53.

23 *Reach* is readily distinguishable from the facts in this case. In *Reach*, the PMAC's powers were circumscribed to a certain degree by its members and the Code was directed at protecting the interests of its members. In Reach, the PMAC's actions were problematic as the association's ruling went beyond the limits of the powers which its members had given it and the ruling adversely affected the interests of a member, Reach M.D. Inc. In the present case, however, Cogeco's unwritten internal policy was not put in place to protect the interests of Drouillard or Mastec. It does not appear that Drouillard or Mastec were aware of or relied on this policy. Further, there was no indication that Cogeco and the employees involved in the decision regarding Drouillard were "not at liberty" to suspend or simply disregard this unwritten policy.

24 *Although the limits of this tort have yet to be set, it would be inappropriate, in my view, to extend the application of this tort to breaches of a corporation's internal policies in circumstances such as those found in this case.*

25 Drouillard argued that Cogeco's actions were arbitrary and in bad faith and that this provided an alternate basis for a finding of illegal or unlawful conduct. While such conduct is not to be encouraged, I do not consider that such conduct, which can be viewed as distasteful, constitutes on the facts of this case unlawful or illegal means. (emphasis added)

[316] In *Correia, supra,* the court considered the interrelationship of negligence with the intentional tort at issue and in particular spoke to the purpose for the existence of the tort:

> [106] A similar analysis applies to the tort of intentional interference with economic relations. Neither Kohler nor Aston intended to cause harm to the appellant by conducting a negligent investigation. Their conduct was not intentional -- at most it was negligent. To the extent that they were reckless as to the consequences of their negligent conduct, recklessness does not amount to an intention to cause harm sufficient to make out the tort.
>
> [107] We note that it is not necessary to fully define the scope of the "unlawful means" component of the tort of intentional interference with economic relations to resolve this case. The contention of the appellant is that the negligent investigation conducted by Aston and Kohler constituted the unlawful means. As discussed above, although Aston may be held responsible in law for such negligence, Kohler may not. Therefore, on any definition, Aston's conduct could amount to unlawful means if it was intended to cause harm to the appellant. The same conduct by Kohler could not. However, again as discussed above, Aston's alleged negligence is directly actionable by the appellant, based on duty of care and foreseeability principles. There is no need to interpose the tort of intentional interference to obtain redress against Aston. The intentional torts exist to fill a gap where no action could otherwise be brought for intentional conduct that caused harm through the instrumentality of a third party. (emphasis added)

Economic Loss

[317] “As with all economic torts, ...’damage is clearly essential to the cause of action and such damage must be seen to have been, or to be about to be, caused by

the unlawful interference." *see, "Remedies in Tort"* (Rainaldi, ed.) (Toronto: Carswell) at §52.

Position of the Plaintiff

[318] The plaintiff asserts that the defendant interfered with AFL, using illegal or unlawful means by *inter alia,* the defendant's violation of the words and spirit of the **OHSA**. It is submitted that the AGNS intended to cause harm to the plaintiff, or in the alternative, that it was willfully blind to the effects of its wrongful acts on the plaintiff's ongoing Amherst operations. They say that the plaintiff suffered economic losses as a result of this tortious conduct by the defendant.

Position of the Defendant

[319] The AGNS says that orders were issued in good faith and in accordance with the powers conferred by statute. The government officials were under a duty to investigate and enforce the provisions of the **OHSA** and the **SEA**, respectively, which they did, and for no improper purpose. The defendant also submits that its' actions did not cause the plant to close.

Analysis

[320] The question is whether the DOL's actions interfered with the economic relations of the plaintiff. If so, was the action unlawful and was it intended to injure the plaintiff?

[321] The actions of the inspection divisions targeted AFL. That was part of the inspection mandate. Each of the defendant's employees involved directly with AFL was aware of the potential to "injure" the company, in as much as responding to a regulator requires the expenditure of resources, and in some instances, quite substantial resources. There is also the potential to injure in a more comprehensive manner as alleged by the plaintiff. *i.e.*, contributing to, or causing the plant to shut down entirely.

[322] In its' argument the plaintiff framed this cause of action as emanating from the conduct of the OHSD only. I will add that I find as a fact that there were no actions of the Fire Marshall's office, nor of the SED that could support a finding of

liability on the basis of an intentional interference with economic relations. I will expand upon this later in my decision.

[323] The activities of the OHSD that are relevant and material to this cause of action are:

- the failure of Inspector Ross to apply internal policies 4.3, 4.6 and 4.7, governing the issuance of Notices and Orders;

- the failure of members of the OHSD to follow internal policy 2.0 outlining the process for the conduct of a Joint Evaluation.

- the expression by Mr. Ross to the union leadership questioning the "fault finding" requirements for the JOSHC;

- the failure of members of the OHSD to ensure the employees' compliance with requirements of section 17 of the **OHSA**;

[324] As to the first element of the tort, I find that the actions of the OHSD employees, as I have set them out, were not motivated by an intention to interfere with the economic relations of the employer and the employees, nor of the employer with any other party.

[325] To the contrary, the evidence overwhelmingly supports the conclusion that the members of the OHSD felt that they were caught in the middle of a rancourous dispute and that their responsibilities, as set out in section 2 of the **OHSA**, were best fulfilled by listening to the complaints, and making objective assessments of the validity of those complaints by means of inspections and orders authorized under the **OHSA.**

[326] The actions complained of by the plaintiff did not give a personal benefit to the government employees involved. I find no malice or bad faith as an alternative explanation for the defendant's conduct. Their actions were not arbitrary, and so I am left with the conclusion that the actions taken were carried out to meet the purposes of the public safety legislation they were employed to enforce.

[327] In the absence of the requisite intent to injure, this cause of action must fail.

[328] In the event that I am wrong in this conclusion, I find that the “policies” in this case were internal documents to the defendant, created by the defendant for the defendant’s use. They were, in effect, guidelines that did not have the force of limiting or otherwise qualifying the statutory responsibilities of the OHSD members. There is nothing in the evidence to suggest that either the defendant or its’ employees were "not at liberty" to act contrary to, or without regard to, the Division’s internal policies.

[329] This position is reinforced by the evidence suggesting that the “policies” pertaining to Joint Evaluations had not been updated to reflect the Division’s practices in the relevant time frame and, in hindsight, were seen as not reflecting the intentions of the Division managers in how or why such a general inspection would be ordered.

[330] The policy setting out the laddered approach for forcing compliance, and which Mr. Ross clearly did not follow, is a particular example of how a policy, though properly framed, and in place for constructive purposes, cannot be used to

fetter the statutory discretion afforded an inspector under the **Act.** The inspector's decisions must be measured against the **Act,** and not an internal policy that is intended for internal use only.

[331] Therefore, the failure to act in accordance with these policies did not render the actions of the defendant "unlawful". Neither were they "illegal".

[332] Mr. Ross's gratuitous comment suggesting that the "fault finding" requirement for the JOHSC "may" be inappropriate was an honestly held view, and not without merit, since those found at fault could be disciplined. This system had the potential to inhibit reporting which would be a serious workplace safety management problem.

[333] However, it was a system that was agreed to in collective bargaining and Mr. Ross had no place in making the comment, particularly as he had made no inquiry to understand that it was a part of the Agreement, or what the company's position was. His comment encouraged the union leadership in their resistance to fulfilling their agreement. It did not, in my opinion, do more than that, and it was not made with an intent to, nor the expectation that it could injure the plaintiff.

[334] It is accurate to say that the unionized employees did not comply with Section 17 of the **OHSA** before contacting the department. It is also true that the DOL required its' employees, when receiving a complaint, to ask and record whether the complainant has complied with the section. *See*, Policy 3.2. It has been established that Mr. LeBlanc and others serving under him, did not make those inquiries when receiving the complaints of Mr. Luedee, Mr. Cormier and others in the union. I accept that the failure to do so contributed to some of the department's lack of appreciation of AFL's approach to safety.

[335] Notwithstanding these facts, there is nothing in the **Act** that mandates that the DOL employees refrain from inspection and compliance actions because of a complainant's failure to follow the requirements of the section. Section 2 of the **OHSA** places the onus for safety in the workplace on the employer and the employees. The departmental role as set out in 2(d) specifically rejects the notion that OHSD has any "responsibility" for creating or maintaining a safe workplace. Instead its' role is to "clarify" the responsibilities of the parties and to "support" them, and only to intervene "appropriately" when those responsibilities are not

being carried out. This language provides a broad discretion to the defendant in how best to meet its' obligations under the Internal Responsibility System.

[336] The failure to enforce compliance by the union employees with their obligations under the section may have been erroneous, but it does not render the consequential actions of the department in response to those complaints unlawful.

[337] As to the third element, I have concluded that the actions of the department did generate expenses for the plaintiff. It is unnecessary to determine the extent to which this occurred.

[338] In summary, I conclude that the defendant did not intend to injure the defendant, and did not engage in illegal or unlawful conduct toward the plaintiff. There was an economic cost, the extent of which is not necessary to resolve, suffered by the plaintiff as a result of the defendant's regulatory actions.

[339] The claim that the defendant intentionally interfered with the economic relations of the plaintiff has not been established and is dismissed.

Misfeasance in Public Office

[340] Executive or administrative power may only be exercised for the public good.

[341] The plaintiff submits that the defendant’s employees engaged in conduct that amounted to “misfeasance in public office.”

[342] Iacobucci J. succinctly described this tort in the case of *Odhavji Estate v Woodhouse* 2003 SCC 69 where he states, at paragraph 32:

> To summarize, I am of the opinion that the tort of misfeasance in a public office is an intentional tort whose distinguishing elements are twofold: (i) deliberate unlawful conduct in the exercise of public functions; and (ii) awareness that the conduct is unlawful and likely to injure the plaintiff. Alongside deliberate unlawful conduct and the requisite knowledge, a plaintiff must also prove the other requirements common to all torts. More specifically, the plaintiff must prove that the tortious conduct was the legal cause of his or her injuries, and that the injuries suffered are compensable in tort law.

[343] The tort is founded on the principle that there is a reasonable expectation for each citizen “... that a public officer will not intentionally injure a member of the public through deliberate and unlawful conduct in the exercise of public functions.” At paragraph 30.

[344] It requires that there be a demonstration of a "...blatant disregard for the interests of those who will be affected by the misconduct in question." At paragraph 29.

[345] LaForme J.A. summarized the elements of the tort in these terms, writing in *1515545 Ontario Ltd. (c.o.b. Fascinations) v. Niagara Falls (City)* 2006 OAC 219:

> 44 The tort of misfeasance in a public office is an intentional tort. Its distinguishing elements are, that the public officer: (i) must have engaged in deliberate and unlawful conduct in the exercise of public functions; and (ii) must have been aware that the conduct was unlawful and likely to injure the plaintiff. Unlawful conduct in this context may be satisfied in two ways. First, it may arise from the direct breach of a statute. Second, it can arise from acting in excess of powers granted or from the use of a valid power for an improper purpose: *Odhavji, supra,* at para. 24, referring to *Three Rivers District Counsel v. Bank of England (No. 3),* [2000] 2 W.L.R. 1220 (H.L.) at 1269.

[346] Most, if not all, of the complained against actions caused a similar "harm" to AFL in that the plaintiff incurred expense and, at least indirectly suffered lost productivity as a result of responding to various inspections, and compliance orders. The plaintiff argues that the actions also contributed to the closure of the plant and so that "harm" was also a direct result of the regulatory oversight.

[347] I have already found as a fact that the conduct of the Office of the Fire Marshall and of the SED was lawful and was not intended to injure the plaintiff. I will expand upon this now.

Office of the Fire Marshall

[348] I find no evidence that the actions of the Fire Marshall's office were either individually, or as part of the broader inspection activities by the defendant, unlawful or intended to injure the plaintiff. The actions taken by Mr. Pilon were authorized by the **Fire Prevention Act**. He did not exceed those powers and he did not exercise them for an improper purpose.

Stationary Engineers Division

[349] The orders issued, and actions undertaken by Mr. Siggars and Mr. Simms were lawful and within their statutory authority. While I question the judgment employed in the refusal of the Minister to exercise his discretion to grandfather any of the AFL employees for certification as crane operators, it was within the Minister's authority to render the decision that he did.

[350] Mr. Simms testified that he knew that the order he issued to AFL on February 12, 2001 would have the effect of closing the plant down. I accept that he would likely have granted a further extension for AFL to achieve compliance, but for the direction given to him by his superior, Mr. Siggars.

[351] What was Mr. Siggars' intention? While he may have been "shocked" that the plant closed, in my view he knew, as a result of his conversation with Mr. Simms, that the plant would close if ordered to immediately comply with the requirement to have certified crane operators. While he was within his authority to require immediate compliance it is necessary to determine whether in doing so he was abusing his authority in such a manner as to attract liability.

[352] I do not accept that it was Mr. Siggars' intent to "injure" AFL. Rather, I conclude that Mr. Siggars honestly believed that the company had been allowed, through its various entreaties to the Department, to unreasonably delay in becoming compliant. There was a risk that an injury or death would take place and that the Division could be complained against for not having forced the company into compliance much sooner. He was not prepared to accept that risk any longer.

[353] The court addressed just such a problem in *Odhavji, supra*, at paragraph 28:

> ...The requirement that the defendant must have been aware that his or her conduct was unlawful reflects the well-established principle that misfeasance in a public office requires an element of "bad faith" or "dishonesty". In a democracy, public officers must retain the authority to make decisions that, where appropriate, are adverse to the interests of certain citizens. Knowledge of harm is thus an insufficient basis on which to conclude that the defendant has acted in bad faith or dishonestly. *A public officer may in good faith make a decision that she or he knows to be adverse to interests of certain members of the public. In order for the conduct to fall within the scope of the tort, the officer must deliberately engage in conduct that he or she knows to be inconsistent with the obligations of the office.* (emphasis added)

[354] In this instance, the actions taken were consistent with the obligations of the office, knowing that they might be adverse to the interests of AFL.

[355] Mr. Siggars' action was only one part of the defendant's response. Within 24 hours, the Deputy Minister and others under his direction addressed the AFL problem successfully, allowing it to reopen. Their actions support the conclusion that while there may have been differences of opinion within the Department as to the best mechanism to bring AFL into compliance, the defendant as judged by the cumulative actions of its employees cannot be shown to have intended to injure the plaintiff, nor to have acted unlawfully toward it.

Occupational Health and Safety Division

[356] The evidence which, in my view, could support the plaintiff's submission that the tort of misfeasance in public office occurred relates to the activities of the Occupational Health and Safety Division. This requires further analysis.

[357] A mood of confrontation evolved over time as between the OHSD and AFL. That generated mutual distrust. The overall inspection activities conducted by Mr. Ross, and in particular the circumstances surrounding the direction for a Joint Evaluation, and the question of who would lead it, fueled the plaintiff's view that they were being unlawfully targeted by the OHSD.

[358] A newspaper article of April 8, 2001 tied the removal of Mr. Ross as head of the Joint Evaluation, by Deputy Minister McNamara, to concerns that AFL was circumventing the process and improperly interfering with the operation of the inspectors. The author of the article raised the specter of the Westray mine explosion of 1992 and stated:

> A weak, easily intimidated government inspectorate contributed to that disaster, an inquiry concluded, so any hint of meddling in the way safety laws are enforced in Nova Scotia is a hot button issue.

[359] The plaintiff points to then Minister David Morse as confirming the malice of the Department toward it by his statement which was included in this article. He is quoted as saying:

> It [AFL] was an employer that was, in my opinion, becoming a little overzealous, and the reward was additional scrutiny of their operations. [the joint evaluation]

[360] This was a poorly thought out comment by a Minister whose department was under public scrutiny. In the context of what was actually taking place with AFL, it was not an accurate assessment.

[361] Three days earlier the same newspaper ran an article entitled *"Province 'caved in', pulled inspector*." It was an article provoked by Mr. Luedee and contributed to by comments of the opposition critic who alleged that Mr. Ross' removal as the head of the joint evaluation team was a direct response to political interference by AFL. At that time Minister Morse denied the allegation. He acknowledged that it was:

> ... unusual for someone other than Mr. Ross, as local officer, to lead the investigation," but went on to say:
>
>> There were concerns on the part of the union that the department was not being vigilant enough, there were concerns on the part of the employer that we were being too vigilant, and since Mr. Ross was in a very difficult situation, we thought it appropriate to bring in the appropriate assistance.

[362] In the same article Mr. Luedee indicated that the union had no problem with Mr. Ross. While that may have been true at a personal level, it would be reasonable for management of DOL to think otherwise, given the number of times that Mr. Luedee and/or Mr. Cormier went over Mr. Ross's head to complain about alleged safety issues in the plant. In November 2000, Mr. LeBlanc specifically noted to Mr. Ross the concern he felt coming from the union that there was inadequate oversight at AFL.

[363] The Minister's comment in this earlier article was more consistent with the opinion of Mr. LeBlanc, expressed to the Deputy Minister in an e-mail of January 11, 2001:

> The comments from the company's side are interesting since Cal Luedee (USWA) is complaining that Alan shouldn't be inspecting this workplace because he is not familiar enough with the industry to see the hazards. Cal's position is that we are not being aggressive enough with the company.

> From whta [sic] I can see we are trying to ensure that the laws are being complied with while not to become [sic] the meat in the sandwich, as the union and the employer developed a working relationship.

[364] This simple statement probably offers one of the clearest insights to the department's intentions. It also notes the irony that both Mr. Luedee and AFL managers thought Mr. Ross was ill equipped to oversee AFL safety.

[365] I do not accept that the reason for the inspection activity of AFL by OHSD was motivated by AFL being "a little overzealous", as the Minister characterized it. I accept that the company's tendency to complain about its' treatment, and to regularly involve Deputy Minister McNamara, was resented by OHSD staff and certainly contributed to the OHSD view that the Internal Responsibility System was not functioning at that plant. Ascertaining the intentions of the inspectors and supervisors for the purpose of assessing whether their actions constituted tortious conduct is more layered.

[366] All of the orders issued to AFL were lawful. Those issued by Mr. Ross were not motivated by an intent to injure AFL, but reflected his extraordinarily narrow view of the policy that intended a "laddered" approach to gaining compliance. He defaulted to the use of Orders where Notices would have sufficed.

[367] It has been stated that Mr. Ross "targeted" AFL. This is true, to the extent that Mr. Ross says he "targeted" AFL and other similar industries where there was a higher risk of injury accidents in the workplace by reason of the work being performed there. Those activities do not support a conclusion that AFL was being singled out disproportionately to other similar plants.

[368] I have previously outlined Mr. Ross's gratuitous comment in his Inspection Report questioning the "fault finding" requirement for the JOHSC . It may have been inappropriate for him to say so, but it was an honestly held view that this system had the potential to inhibit reporting, which would be a serious workplace safety management problem.

[369] For the purposes of determining whether it could amount to an act of "malfeasance", I conclude that it was not unlawful to have expressed the opinion, only ill advised. Mr. Ross certainly had not conceived of his comment being unlawful, and I doubt he turned his mind to what the consequences might be other than to support a position that would eliminate a procedure that he thought might contribute to an unsafe workplace.

[370] The decision to order a Joint Evaluation may be justly criticized for the failure to more carefully assess the validity of the union's complaints; for failing to be more flexible with the employer - allowing that perhaps they had good reason to be upset with some aspects of the oversight they were being subjected to; and for failing to follow internal policy with respect to the conduct of a joint evaluation. I find no evidence that anyone in the OHSD engaged in the decision to conduct the Evaluation to "injure" the plaintiff. While some information presented was within the knowledge of Alan Ross as being incorrect, there were safety concerns identified which were clearly legitimate. *i.e.,* a number of injury accidents; the lack of training for new hires (new employees were not offered the same training program that was offered in August and September of 1999 to employees).

[371] There is no evidence that anyone in OHSD contemplated that any of their actions might be perceived as "unlawful". Mr. LeBlanc and Mr. O'Neil were struck by the rancour between employer and union and observed that the Department was getting complaints from both sides. It was not unreasonable to conclude that the evaluation had the best hope of creating an objective view of

what, if any, safety problems existed at AFL. That was a function squarely within the mandate of the Department.

[372] In summary, the defendant's employees did not engage in unlawful conduct during the exercise of their public functions. They conducted themselves confident in the belief that their actions were within the statutorily mandated powers afforded them and that they were pursuing a safe workplace, with a functioning IRS.

[373] I conclude that the plaintiff has not met the burden to establish that the defendant engaged in misfeasance in public office.

Conspiracy

[374] The plaintiff says that the defendant is liable for damages as a result of its' conspiracy with the International, or the Local, or both.

[375] The scope of the tort was described in *Canada Cement LaFarge Ltd. v. British Columbia Lightweight Aggregate Ltd.,* [1983] 1 S.C.R. 452 at pages 471-2, per Estey J.:

> Although the law concerning the scope of the tort of conspiracy is far from clear, I am of the opinion that whereas the law of tort does not permit an action against an individual defendant who has caused injury to the plaintiff, the law of torts does recognize a claim against them in combination as the tort of conspiracy if:
>
> (1) whether the means used by the defendants are lawful or unlawful, the predominant purpose of the defendants' conduct is to cause injury to the plaintiff; or,
>
> (2) where the conduct of the defendants is unlawful, the conduct is directed towards the plaintiff (alone or together with others), and the defendants should know in the circumstances that injury to the plaintiff is likely to and does result.
>
> In situation (2) it is not necessary that the predominant purpose of the defendants' conduct be to cause injury to the plaintiff but, in the prevailing circumstances, it must be a constructive intent derived from the fact that the defendants should have known that injury to the plaintiff would ensue. In both situations, however, there must be actual damage suffered by the plaintiff.

[376] In *Nicholls v. Richmond (Township)*, [1984] 3 W.W.R. 719 (B.C.S.C.), McLachlin J. (as she then was) reviewed the requirements of the tort in the following terms:

> 35 The requirements of conspiracy to injure the plaintiff are an agreement between two or more persons whose predominant purpose is to injure the plaintiff and which when acted upon results in damage to the plaintiff. It is not a requirement that the conduct of the defendants in effecting their agreement be unlawful.

> 36 The requirements of the second type of conspiracy, conspiracy by unlawful means, are an agreement between two or more persons which is effected by unlawful conduct where the defendants should know in the circumstances that damage to the plaintiff is likely to ensue and such damage does in fact ensue. Unlike the first category of conspiracy, it is not a requirement of conspiracy by unlawful means that the predominant purpose of the defendants be to cause injury to the plaintiff. Rather a constructive intent is derived from the fact that the defendants should have known that damage to the plaintiff would result from their conduct.

[377] The plaintiff submits that the evidence in the case at bar supports a finding of conspiracy under both categories.

[378] The plaintiff argues that there is circumstantial evidence before the court on which to find that a conspiracy existed as between the International Union and/or the Local, acting together with the defendant, to cause injury to the plaintiff. The plaintiff does not argue the existence of direct evidence of a conspiracy and indeed there is none.

[379] The court in *Nicholls v. Richmond (Township),supra,* had occasion to consider the use of circumstantial evidence, as proffered by the plaintiff in this case, for proof of the "agreement":

> 38 On either category of conspiracy, the plaintiff must show more than that the defendants independently intended to injure the plaintiff or to commit an unlawful

act; an agreement must be established: *Mulcahy v. R.* (1863) 3 L.R. 306 (H.L.) at p.317; *Crofter v. Veitch* [1942] A.C. 435 (H.L.) at p.469.

39 "Agreement" is not used in the formal sense of a binding contract but rather in the sense of a joint plan or common design: *Humphry v. Wilson*, (1917) 3 W.W.R. 529 (B.C.S.C.); *Gee v. Freeman* (1958) 16 D.L.R. (2d) 65 (B.C.S.C.).

40 Such an agreement can be proved by direct evidence. But it may also be inferred if the facts justify its inference on the basis of the following test set out by the Lord Chancellor in *Sweeney v. Coote* [1907] A.C. 221 (H.L.) at p.222:

> " In such a proceeding [i.e. where civil conspiracy is alleged] it is necessary for the plaintiff to prove a design, common to the defendant and to others, to damage the plaintiff, without just cause or excuse. That, at all events, it is necessary to prove. Now, a conclusion of that kind is not to be arrived at by a light conjecture; *it must be plainly established*. It may, like other conclusions, be established as a matter of inference from proved facts, but the point is not whether you can draw that particular inference, but whether the facts are such that they cannot fairly admit of any other inference being drawn from them." (emphasis added)

This test was applied in both *Humphrey v. Wilson, supra* and *Gee v. Freeman, supra.*

[380] The principle points of contact as between the defendant and the union leadership that provided the opportunity to form an agreement were:

- Alan Ross's unilateral discussions with the union executive;

- James LeBlanc's unilateral discussions with Cal Luedee and Barry Cormier;

- The “Springhill Meeting” and resulting Joint evaluation;

[381] I will begin by examining the chronology of the relationships among the three protagonists.

[382] In the latter part of 1999 and into the first half of 2000 there was little or no contact as between the union and the defendant’s employees. The union filed a few grievances but their main disputes with the company had not yet translated into action.

[383] As between the plaintiff and defendant there were the issues of the flashback arrestors which did not involve the union, and the crane operators’ certification under the **Stationary Engineers Act**, which similarly did not involve the union. In each case, the defendant’s employees embarked on their inspection and compliance activities unilaterally and as part of their routine activity.

[384] Mr. Ross’s first visit to the plant was in June, 1999, and he immediately gave evidence of his philosophy of defaulting to orders. There is no evidence

showing union input to his approach. He did not return to the plant until March of 2000.

[385] The operative time for the "conspiracy" to have formed would have been in the period of June 2000 to April 2001. The conflict as between employer and employee became manifest. There were injury accidents in which union members were being found at fault by the JOHS Committee. The employer's emphasis on production and its' disregard for the DBC way of running the plant were irritants to the union leadership. The union filed 48 grievances in the last 6 months of 2000 alone.

[386] Mr. Luedee complained to Mr. LeBlanc in June, August and November 2000. The latter two complaints caused Mr. LeBlanc to delegate Mr. Ross to attend at AFL to determine the validity of the complaints. The August complaint resulted in the issuance of one order. The December inspection resulted in the nine compliance orders being handed to AFL. They were consistent with the philosophy of Mr. Ross to prefer orders over Notices to comply.

[387] The timing of Mr. Luedee's complaints was directly related to employer activities which he and the Local took exception to. *i.e.*, fault finding determinations in the Trenholm and Manship accidents, and the disputes between employer and union with the operations of the JOHS Committee.

[388] I am satisfied that the union was "tipped off", perhaps inadvertently, by Alan Ross to the December 2000 inspection. For what reason is not clear.

[389] After the November complaint, Mr. LeBlanc and Mr. O'Neil concluded that there were major problems in the operation of the IRS at AFL. It was in early December that a "general inspection," characterized as a Joint Evaluation, was identified as the mechanism for the Division to sort out what the true state of safety was at the AFL plant. It arose as a topic at the Division's Christmas function. There is no evidence that Mr. Luedee participated in or otherwise had a role in initiating this method of addressing the AFL issues. It was arranged solely on the impetus of OHSD officials.

[390] The evidence demonstrates that the DOL's intention of conducting a Joint Evaluation was made known to Cal Luedee before January 9, 2001. The plaintiff

was not consulted and had no inkling of the discussions at OHSD, or by OHSD with Mr. Luedee, until later in January when notified that it was going to take place.

[391] The defendant, in receiving and acting on the union complaints, ignored its' obligation to ensure that the union had complied with Section 17 of the **OHSA,** and ignored the internal policy intended to ensure that the regulator confirmed compliance before taking action. The pitfalls of not having done so are self evident in this case.

[392] The Springhill meeting was a further example of unilateral contact in which complaints were made and the regulator's response was outlined, all to the exclusion of the employer. The regulators made commitments to a joint evaluation and to employ an outside expert to examine crane operations, both without first consulting the employer.

[393] After the Joint Evaluation, the plant had a very short period of operation. The union's respirator complaint triggered departmental action, but was not sustained. There is no evidence that the union was directly or indirectly involved

in Departmental decisions to evaluate the rigging practices, nor to pursue the prosecution in Provincial Court.

[394] The plaintiff's perspective is not unwarranted in light of these events. The steps taken by OHSD were one sided, and reflected a lack of concern for the position of the employer. This was aggravated by the fact that so much of what was being reported to them was readily ascertainable as inaccurate.

[395] No good reason has been offered by the defendant to explain these lapses. On the other hand there is no evidence to support the notion that the defendant stood to gain advantage by its conduct.

[396] The principle union goal in complaining directly to DOL was to gain its' assistance in pressuring the company to back away from its insistence on fault finding by the JOHSC. Other purposes that I attribute to the union conduct was the desire to harass the employer into giving the union greater control over the workplace and the production. While I believe that safety in the workplace was important to the union representatives, it was being used as a vehicle to involve DOL and thus to facilitate the overriding purpose of the union wielding greater

influence in plant operations. Applying a generous definition of the term, it could be said that the union sought to injure the company.

[397] The question is whether the facts support a finding that the defendant agreed to assist in effecting their purpose. In my view there is another conclusion that can fairly drawn from the facts as I have found them.

[398] Mr. Ross' conduct was consistent throughout and there is no evidence to support a conclusion that the union affected his approach to inspecting AFL. His comment that questioned the employer's position as to fault finding was, in my view, an honestly held view as to the safety concerns the practice might generate.

[399] Mr. LeBlanc knew Mr. Luedee and was rightly suspicious of his approaches to DOL. He was unlikely to form agreements with him, but neither could he afford to ignore Mr. Luedee's complaints.

[400]   Mr. O'Neil incorrectly, for the most part, assessed AFL as being obstreperous because of its responses to regulator activity. It colored his judgement in how to best address the problems at AFL, but again had little to do

with the union's purposes. Concurrent to his involvement he expressed the view that he wanted Mr. Leudee "out of [OHS'] hair" - a comment that is not indicative of seeking common purpose with the union.

[401] I find that Mr. LeBlanc and Mr. O'Neil's intention throughout was to fulfill the division's responsibilities under Section 2(d) of the **OHSA**. It was apparent that the IRS was not functioning as it was intended. The decision to conduct a Joint Evaluation was probably the best solution to provide them with an objective view of plant safety and I accept that they assessed it that way.

[402] Rather than entering into an agreement with the union, the DOL actions were the product of cause and effect. They received a complaint alleging that plant safety was a problem and they responded, relying on the inspection tools provided by statute. They recognized that they were being caught in the middle of the dispute between AFL and its unionized employees and were looking for a solution to resolve the problem. They did so independently of the union.

[403] The means that were employed by the OHSD were lawful. To the extent that they generated expense to the plaintiff, I conclude that was not the predominant purpose of the defendant's officials.

[404] In summary, this cause of action fails for want of evidence establishing a common design or agreement as between the defendant and the union. The defendant's predominant purpose was to ensure compliance with good safety practices and to gain an objective assessment of the functioning of the IRS, with a view to directing corrections where necessary. It carried out its' function employing lawful means.

[405] The claim that the defendant conspired with the union against the plaintiff has not been established and is dismissed.

Regulatory Negligence

Introduction

[406] The plaintiff submits that the evidence has established that the defendant was negligent in the conduct of its' regulatory activities at AFL and that it is liable to the plaintiff as a result. For this argument to succeed the plaintiff must demonstrate that:

i) the defendant owed a duty of care to the plaintiff;

ii) there was a breach of the duty of care; and

iii) the defendant's breach caused the plaintiff to suffer a loss in fact and in law.

Position of the Plaintiff

[407] The Plaintiff submits that the **OHSA** establishes a limited duty of care owed by the DOL to employers, such as Cherubini, and to employees. It is the policy established by the tripartite nature of the Internal Responsibility System described in Section 2 of the **OHSA** which creates that duty.

[408] The plaintiff says that the defendant negligently carried out its obligations to the plaintiff, and thereby breached its' duty of care to the employer, and which caused the plaintiff to suffer a compensable loss.

[409] The harm alleged in this case is the defendant's contribution to the dysfunctional operation of the IRS at the plant and its role in the employee unrest, which in turn contributed to ongoing costs to the employer and ultimately to the shutdown of the plant.

[410] This argument has not been advanced in relation to the actions of the Fire Marshall, acting under the **Fire Prevention Act,** nor has the plaintiff advanced the argument in relation to the conduct of persons acting pursuant to the **Stationary Engineers Act**. Although a duty of care may be found for inspection actions by the DOL in its administration of the **OHSA** , it does not automatically import a duty in relation to inspection activities by other divisions within the DOL.

[411] It is evident upon a review of the respective statutes and the facts, that the plaintiff's argument in negligence will succeed or fail on the basis of the conduct of the OHSD.

Position of the Defendant

[412] The defendant argues against the plaintiff's conclusion relying on recent trends in the law of negligence which tend to rule against finding a private law duty of care owed by a regulator. While the defendant acknowledges that such a duty can exist, it says that such a duty should be found rarely and only when there is a clear statutory intent that one should exist.

[413] The defendant says that the **OHSA** should not be read to establish such a duty as the plaintiff seeks, since it would have a significant chill on the regulator. It would generate a duty to too broad a group and is contrary to public policy.

[414] In the alternative, the defendant says that even if a duty of care should be found to exist, that there was no breach of the duty, and in the further alternative, any breach that may be found did not cause a compensable loss to the plaintiff.

Duty of Care

[415] The law will impose a duty of care on a person if he or she ought to foresee a risk of harm, is in proximity to those at risk and it is not unwise, for policy reasons, to do so. *see*, *Elliott v. Insurance Crime Prevention Bureau* 2005 NSCA 115, at paragraph 37.

[416] In *Elliot, supra*, Cromwell J.A.,(as he then was) outlined a step by step analysis to determine the existence or absence of a duty of care. He states:

> 47 It will be helpful first to situate the proximity issue in the broader context of a duty of care analysis. In a novel case (that is, one in which a duty of care has not been authoritatively recognized before), the existence of a duty of care is tested by applying the analysis from *Anns v. Merton London Borough Council* and *Kamloops (City) v. Nielsen,* [1984] 2 S.C.R. 2. That test was described as follows in *Cooper v. Hobart* at para. 30:
>
>> 30 In brief compass, we suggest that at this stage in the evolution of the law, both in Canada and abroad, the *Anns* analysis is best understood as follows. At the first stage of the *Anns* test, two questions arise: (1) was the harm that occurred the reasonably foreseeable consequence of the defendant's act? and (2) are there reasons, notwithstanding the proximity between the parties established in the first part of this test, that tort liability should not be recognized here? The proximity analysis involved at the first stage of the *Anns* test focuses on factors arising from the relationship between the plaintiff and the defendant. These factors include questions of policy, in the broad sense of that word. If foreseeability and proximity are established at the first stage, a *prima facie* duty of care arises. At the second stage of the *Anns* test, the question still remains whether there are residual policy considerations outside the relationship of the parties that may negative the imposition of a duty of care. ...
>
> 48 Foreseeability alone is not sufficient to establish a *prima facie* duty of care. In addition, the appellants must establish proximity - that the relationship between

the respondents and the appellants is such that it is just and fair to impose a duty of care: *Odhavji Estate v. Woodhouse,* [2003] 3 S.C.R. 263 at para. 55; *Donoghue v. Stevenson*, [1932] A.C. 562 (H.L.) at 581; *Cooper* at para. 32. The nature of this inquiry was summed up by Iacobucci, J. in *Odhavji* at para. 50:

> [50] Consequently, the essential purpose of the inquiry is to evaluate the nature of that relationship in order to determine whether it is just and fair to impose a duty of care on the defendant. The factors that are relevant to this inquiry depend on the circumstances of the case. As stated by McLachlin J. (as she then was) in *Norsk*, [1992] 1 S.C.R. 1021, *supra*, at p. 1151. "[p]roximity may be usefully viewed, not so much as a test in itself, but as a broad concept which is capable of subsuming different categories of cases involving different factors" (cited with approval in *Hercules Managements*, [1997] 2 S.C.R. 165, *supra*, at para. 23, and *Cooper, supra,* at para. 35). Examples of factors that might be relevant to the inquiry include the expectations of the parties, representations, reliance and the nature of the property or interest involved.

49 In *Cooper*, the Court indicated that sufficiently proximate relationships are identified through the use of categories. While the law may develop new ones, the starting point for the proximity analysis should be the existing categories in which proximity has been found: para. 31. If there is no closely analogous category, the question of whether there is a duty of care must be answered by applying the full *Anns/Kamloops* analysis....

[417] The first question then is to determine whether this is a case where a duty of care has been previously "authoritatively recognized," or is sufficiently analogous thereto. If so, and if reasonable forseeability of harm is shown, then a *prima facie* duty of care may be posited.

[418] Chief Justice McLachlin, writing with Major J., in *Cooper v. Hobart,* 2001 SCC 79, listed the recognized "categories". That which is relevant to the plaintiff's argument was set out in paragraph 36:

> 36 What then are the categories in which proximity has been recognized? First, of course, is the situation where the defendant's act foreseeably causes physical harm to the plaintiff or the plaintiff's property. This has been extended ... Again, a municipality has been held to owe a duty to prospective purchasers of real estate to inspect housing developments without negligence: *Anns, supra; Kamloops, supra.* Similarly, governmental authorities who have undertaken a policy of road maintenance have been held to owe a duty of care to execute the maintenance in a non-negligent manner: *Just v. British Columbia,* [1989] 2 S.C.R. 1228, *Swinamer v. Nova Scotia (Attorney General),* [1994] 1 S.C.R. 445, etc. ... When a case falls within one of these situations or an analogous one and reasonable foreseeability is established, a *prima facie* duty of care may be posited.

[419] The starting point of the plaintiff's analysis is that the necessary proximity is evidenced in Sections 2(d) and 9(c) of the **OHSA**. For ease of reference those subsections read:

> 2 The foundation of this Act is the Internal Responsibility System which
>
> ...
>
> > (d) is supplemented by the role of the Occupational Health and Safety Division of the Department of Labour, which is not to assume responsibility for creating and maintaining safe and healthy workplaces, but to establish and clarify the responsibilities of the parties under the law, to support them in carrying out their responsibilities and to intervene appropriately when those responsibilities are not carried out. 1996, c. 7, s. 2.

...

9 The Division shall

...

> (c) provide assistance to persons concerned with occupational health and safety and provide services to assist joint occupational health and safety committees, health and safety representatives, employers, employees and self-employed persons in maintaining reasonable standards for the protection of the health and safety of employees and self-employed persons;

[420] The plaintiff suggests that these legislative provisions "...confirm a direct and proximate role for the AGNS as advisor and assistant to employers in the goal of creating a safe working environment."

[421] This position seeks to affix liability to the defendant for the manner in which the OHSD staff carried out not just its inspection activities, but also the manner in which it provided support and assistance as mandated by these two subsections. *Cooper, supra,* informs that the inspection activities of a regulator fall within a recognized category on which a *prima facie* duty of care might be founded. However, the courts have not, to this point, recognized the much broader basis on which the plaintiff asserts the existence of a duty of care in this case. To the extent

that this case involves inspection activities and that there exists possibly analogous cases, I note that there has been no judicial determination of the existence of a duty of care generated on the basis of the inspection requirements of the **OHSA.** The question is, therefore, whether the law of negligence should be extended to encompass this situation.

[422] In view of this, an analysis must be conducted employing the *Anns* test. The first step is to determine whether the harm that occurred was the reasonably foreseeable consequence of the defendant's act? There are, per the court's decision in *Cooper, supra,* policy considerations at this first stage which will need to be assessed to determine if the defendant should be exempted from a finding of a duty of care.

[423] I agree with the plaintiff that Sections 2(d) and 9(c) create a special relationship as among the OHSD, the employer and the employees.

[424] The language in Section 2 mandates that workplace safety is the responsibility of the latter two parties. In my view, the operative provision of Section 2(d) that goes to the establishment of a duty is found in the phrase "... to

support them in carrying out their responsibilities and to *intervene appropriately* when those responsibilities are not carried out." These are the first principles upon which the support, inspection and compliance regime in the **Act** are based. If the regulator negligently performs these functions then it is reasonably forseeable that harm, such as avoidable workplace injuries, could occur. Similarly, if the regulator intervention is inappropriate, then there exists the potential that it may constitute negligent conduct which could forseeably cause harm to either or both of the employer and the employees.

[425] Section 9 carries a mandatory direction to OHSD to provide assistance to the employers, employees and the JOHS Committees for the purpose of ensuring that "reasonable standards" are in place to ensure workplace safety. It is reasonably forseeable that a negligent failure to provide that assistance could result in harm in the workplace - an ineffective or substandard safety prevention program could contribute to the creation of an unsafe workplace resulting in loss to either or both of the employer and employees.

[426] This legislative regime, including inspections, creates expectations in the employers and the employees as to what they should reasonably expect from the OHSD in ensuring a functioning IRS and a safe workplace.

[427] The Supreme Court of Canada stated in *Hercules Managements Ltd. v. Ernst & Young,* [1997] 2 S.C.R. 165, at paragraph 24, per La Forest J.:

> The label "proximity", as it was used by Lord Wilberforce in *Anns, supra,* was clearly intended to connote that the circumstances of the relationship inhering between the plaintiff and the defendant are of such a nature that the defendant may be said to be under an obligation to be mindful of the plaintiff's legitimate interests in conducting his or her affairs.

[428] At this stage of the analysis, I accept that the OHSD should, by virtue of the relationship created in these provisions, be "mindful" of the legitimate interests in the conduct of the affairs of those identified in Sections 2 and 9. I conclude that there is a statutory and factual basis on which to conclude that there is a *prima facie* duty of care imposed on the defendant to act reasonably in the administration of the regulatory provisions of the **OHSA.**

[429] I turn now to the bases on which a public actor may be exempted from liability.

[430] In *Just, supra,* Cory J. addressed the relevant principles:

> 28 It may be convenient at this stage to summarize what I consider to be the principles applicable and the manner of proceeding in cases of this kind. As a general rule, the traditional tort law duty of care will apply to a government agency in the same way that it will apply to an individual. In determining whether a duty of care exists the first question to be resolved is whether the parties are in a relationship of sufficient proximity to warrant the imposition of such a duty. In the case of a government agency, exemption from this imposition of duty may occur as a result of an explicit statutory exemption. Alternatively, the exemption may arise as a result of the nature of the decision made by the government agency. That is, a government agency will be exempt from the imposition of a [page1245] duty of care in situations which arise from its pure policy decisions.

[431] In the case at bar there is no statutory exemption to the imposition on the defendant of a duty of care owed to the plaintiff.

[432] The rationale for a judicial reluctance to attach liability to "policy decisions" was described at an earlier point in *Just*:

> 16 The functions of government and government agencies have multiplied enormously in this century. Often government agencies were and continue to be the best suited entities and indeed the only organizations which could protect the public in the diverse and difficult situations arising in so many fields. They may encompass such matters as the manufacture and distribution of food and drug products, energy production, environmental protection, transportation and tourism, fire prevention and building developments. The increasing complexities of life involve agencies of government in almost every aspect of daily living. Over the passage of time the increased government activities gave rise to

> incidents that would have led to tortious liability if they had occurred between private citizens. The early governmental immunity from tortious liability became intolerable. This led to the enactment of legislation which in general imposed liability on the Crown for its acts as though it were a person. However, the Crown is not a person and must be free to govern and make true policy decisions without becoming subject to tort liability as a result of those decisions. On the other hand, complete Crown immunity should not be restored by having every government decision designated as one of "policy". Thus the dilemma giving rise to the continuing judicial struggle to differentiate between "policy" and "operation". Particularly difficult decisions will arise in situations where governmental inspections may be expected.
>
> 17 The dividing line between "policy" and "operation" is difficult to fix, yet it is essential that it be done. ...
>
> 18 ...True policy decisions should be exempt from tortious claims so that governments are not restricted in making decisions based upon social, political or economic factors. However, the implementation of those decisions [page1241] may well be subject to claims in tort. What guidelines are there to assist courts in differentiating between policy and operation?
>
> 19 Mason J., speaking for himself and one other member of the Australian High Court in *Sutherland Shire Council v. Heyman* (1985), 60 A.L.R. 1, set out what I find to be most helpful guidelines. He wrote:
>
>> ..The standard of negligence applied by the courts in determining whether a duty of care has been breached cannot be applied to a policy decision, but it can be applied to operational decisions.
>
> 20 The duty of care should apply to a public authority unless there is a valid basis for its exclusion. A true policy decision undertaken by a government agency constitutes such a valid basis for exclusion...

[433] Although the plaintiff has framed the “duty” in this case as expanding beyond the parameters of the inspection activity of the defendant, the same

considerations are relevant to assessing whether the provisions of the **OHSA** trigger policy or operational considerations.

> 21 The decisions in *Anns v. Merton London Borough Council and City of Kamloops v. Nielsen, supra*, indicate that a government agency in reaching a decision pertaining to inspection must act in a reasonable manner which constitutes a *bona fide* exercise of discretion. To do so they must specifically consider whether to inspect and if so, the system of inspection must be a reasonable one in all the circumstances.
>
> 22 ...Thus a decision either not to inspect at all or to reduce the number of inspections may be an unassailable policy decision. This is so provided it constitutes a reasonable exercise of *bona fide* discretion based, for example, upon the availability of funds.
>
> 23 ... Thus once the policy decision to inspect has been made, the Court may review the scheme of inspection to ensure it is reasonable and has been reasonably carried out in light of all the circumstances, including the availability of funds, to determine whether the government agency has met the requisite standard of care.
>
> ...
>
> 29 In determining what constitutes such a policy decision, it should be borne in mind that such decisions are generally made by persons of a high level of authority in the agency, but may also properly be made by persons of a lower level of authority. The characterization of such a decision rests on the nature of the decision and not on the identity of the actors. As a general rule, decisions concerning budgetary allotments for departments or government agencies will be classified as policy decisions. Further, it must be recalled that a policy decision is open to challenge on the basis that it is not made in the *bona fide* exercise of discretion. If after due consideration it is found that a duty of care is owed by the government agency and no exemption by way of statute or policy decision-making is found to exist, a traditional torts analysis ensues and the issue of standard of care required of the government agency must next be considered.

> 30 The manner and quality of an inspection system is clearly part of the operational aspect of a governmental activity and falls to be assessed in the consideration of the standard of care issue. At this stage, the requisite standard of care to be applied to the particular operation must be assessed in light of all the surrounding circumstances including, for example, budgetary restraints and the availability of qualified personnel and equipment.

[434] The legislature in enacting the **OHSA**, and in particular the provisions of Sections 2, 9, and 47-57 (Officers, Inspections and Orders) made a policy decision to support, assist and intervene in workplaces to pursue the public interest in workplace safety, while being mindful of the mutual obligations of employers and employees. Therefore the operational activities of the OHSD in fulfilling this policy goal are subject to scrutiny to ensure that the mechanism by which the policy is given effect is itself reasonable, and that the activities carried out in furtherance of that role are conducted reasonably. I find this to be so for all aspects of the OHSD responsibilities under the policy and not just the inspection activities.

[435] The defendant argues that there are other reasons exempting it from the duty of care asserted by the plaintiff:

i) That there are adequate administrative law remedies in the **OHSA** so as to negative the scope of a *prima facie* duty of care;

ii) That there is a prospect of unlimited liability to an unlimited class;

iii) That to impose a duty of care could have a "chill" on the regulator in the exercise of its responsibilities.

[436] I reject these as a basis on which to exempt the OHSD from owing a duty of care to employers and employees in the manner in which it carries out its operational duties pursuant to the **OHSA.**

[437] There is a limited right of appeal set out in Section 67 of the **OHSA** which addresses the decisions of inspectors to make or refrain from making orders. The operational activities of the OHSD are broader than this and should they negligently fail to fulfill responsibilities to assist, support or intervene appropriately (which does not always connote the issuance of Notices, Orders, or prosecution) then the **Act** does not provide a remedy. Further, remedies that are available are limited and may not adequately address the compensation that the negligent conduct merits. e.g., a failure to issue a compliance order may result in harm in the workplace before the appeal process can correct that decision.

[438] The class of persons to whom this duty is owed is readily identifiable and should not be measured by the number of persons within the class. The concern is to ensure that there is not open ended liability. That is not the case with the **OHSA.**

[439] The regulator should not experience a "chill" as alleged. The **Act** provides a broad discretion in how the regulator can achieve its objectives. In any event, a balancing of that potential consequence against the public interest in ensuring that the OHSD fulfills its responsibilities to ensure safe workplaces resolves in favour of imposing a duty.

[440] OHSD officials have an obligation to the public which is implied though not necessarily specified in the **Act.** The minimization of the number and severity of worker injuries directly impacts on the public purse. The cost to the taxpayers in health benefits and other compensation necessary for injured workers is a taxpayer burden that has to be recognized. Lost productivity is a cost to the taxpayer. The plaintiff says that regulatory negligence cost it substantial amounts of money, the loss of many jobs, and an important industry to a small town. Whether that is so in

this case, the potential exists and the public has a right to expect that the regulator will responsibly meet its duty to avoid such consequences.

[441] I conclude that the defendant owed a duty of care to the plaintiff to reasonably, and not negligently, fulfill its obligations under the **OHSA.**

Standard of Care

[442] A useful statement of the applicable standard of care is set out in *Swanson Estate v. Canada (F.C.A.)* [1991] F.C.J. 452 at p. 9:

> The government is not an insurer; it is not strictly liable for all air crashes, only for those caused by the negligence of its servants. The standard of care required of these inspectors, like every other individual engaged in activity, is that of a reasonable person in their position. What is required of them is that they perform their duties in a *reasonably competent way*, to behave as would reasonably competent inspectors in similar circumstances, no more and no less. In evaluating their conduct, courts will consider custom and practice, any legislative provisions and any other guidelines that are relevant. The risk of harm and its severity will be balanced against the object and the cost of the remedial measures. In the end, the court must determine whether the employees of the defendant lived to or departed from the standard of care demanded of them, in the same way as in other negligence cases. (See, generally, Fleming, *The Law of Torts,* (7th ed. 1987) at p. 96.) (emphasis added)

[443] While the following comments of Justice Cory, in *Just, supra*, are directed toward the standard of care in "inspection cases" it is a meaningful guide to setting the standard of care:

> 23 ... Thus once the policy decision to inspect has been made, the Court may review the scheme of inspection to ensure it is reasonable and has been reasonably carried out in light of all the circumstances, including the availability of funds, to determine whether the government agency has met the requisite standard of care.
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> ...
>
> 26 The consideration of the duty of care that may be owed must be kept separate and distinct from [page1244] the consideration of the standard of care that should be maintained by the government agency involved.
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> 27 ... The governmental agency should be entitled to demonstrate that balanced against the nature and quantity of the risk involved, its system of inspection was reasonable in light of all the circumstances including budgetary limits, the personnel and equipment available to it and that it had met the standard duty of care imposed upon it.
>
> ...
>
> 30 The manner and quality of an inspection system is clearly part of the operational aspect of a governmental activity and falls to be assessed in the consideration of the standard of care issue. At this stage, the requisite standard of care to be applied to the particular operation must be assessed in light of all the surrounding circumstances including, for example, budgetary restraints and the availability of qualified personnel and equipment.

[444] To succeed the plaintiff must show that the OHSD officials did not act in a reasonably competent way, having regard to the nature and severity of the risk, the industry custom and practices and relevant guidelines available. These factors must be balanced against the surrounding circumstances including the availability of qualified personnel and the relative costs of remedial measures.

Breach of Duty of Care

[445] The actions of the OHSD inspectors and management have been extensively described in the discussion of other alleged torts.

[446] Mr. Ross intervened at AFL primarily by his inspection activities. His conduct, notwithstanding his inexperience in the industry, was consistent with his statutory obligations, as set out in Sections 47-57 of the **Act.** His practice of defaulting to orders was not consistent with the divisional policy, nor the practices

of other inspectors, but those factors could not render his actions as less competent, only more conservative in applying the law.

[447] His orders were subject to appeal. Some of his orders were appealed and found to be lawful. Others of his orders were appealed and the plaintiff abandoned those appeals. Some orders were not appealed. In the absence of any successful appeal, I find the orders to have been lawful. It is my further view that if the orders are lawful, there can be no breach of the duty of care in respect of the orders.

[448] The inspections and the orders emanating from the Joint Evaluation, and the rigging assessment were effected in accordance with statutory obligations and custom. The plaintiff alleges that certain of the rigging orders reflected incompetence on the part of the inspector. It may be that the practice directions were flawed, but the plaintiff's attempted appeal was not successful and so I am not prepared to find that the issuance of those orders was negligent.

[449] Other activities of OHSD officials are to be assessed against the obligations to assist and support as set out in Section 2 of the **Act**. The statute provides a

broad discretion to the Divisional officials in determining how to fulfill these functions.

[450] Mr. Ross' comments in December 2000 as to the potential negative impacts of the fault finding provision of the Collective Agreement was inappropriate and clearly contrary to the role of the DOL under Section 2 (d) of the **Act**. For reasons which I will explain later however, it was not causative of a loss.

[451] The OHSD officials' conduct in reaching a decision to order a Joint Evaluation is also troubling. Again, obligations under Section 2(d) of the **Act** were ignored. No one confirmed compliance of the union with their obligations under Section 17 of the **OHSA.** Little effort was expended in determining the validity of the union complaints. Incorrect conclusions were reached in assessing the attitude of the employer in its responses to the regulator's actions to date.

[452] Having acknowledged the very flawed process employed to order a joint evaluation, the question remains as to whether doing so was unreasonable and thus a breach of the standard of care. I have concluded that it was not.

[453] The core problem underpinning Mr. Ross' comments in December of 2000, and the decision to order a Joint Evaluation, was a poorly functioning IRS. The reasons were largely driven by the union leadership. The defendant correctly recognized the labour-management problem and was attempting to find a mechanism to get the parties to work together and, to borrow Mr. O'Neil's phrase, get them "out of OHS' hair". The range of options available to OHS were limited. It would have been preferable that they consulted with the employer before ordering the evaluation - to hear both sides of the issues complained of. That may have generated a different and less intrusive response, but with the existing communication problems as between AFL management and OHSD, it is speculative to say that it would be so. In reality, OHSD had to make an independent and credible assessment of the workplace safety at AFL if it were to have any hope of stemming the union efforts to drag it into their dispute with the employer. In one sense, it had the potential to assist the employer in its disagreements with the union. I am satisfied, however, that senior officials of the union were determined not to make the relationship work with the employer under any circumstances.

[454] For these reasons, I do not find the comments of Mr. Ross in 2000 nor the decision to order a joint evaluation to breach the duty of care owed by the defendant to the plaintiff, or to be causative of a loss. In making this determination, I am also determining that there was no material contribution to a loss by these activities as contemplated by the decision of the Supreme Court of Canada in *Athey v. Leonati* [1996] 3 S.C.R. 458.

[455] Further, I am not satisfied that there was a causal link between the actions of the OHSD and the closure of the plant. In my view, that result is solely attributable to the employees' inability to produce the quantity and quality of product necessary to meet the expectations of Cherubini.

[456] The parent company had the ability and a plan to delegate contracts to AFL. AFL was not intended at that time to seek out and obtain its' own contracts. Cherubini had the capacity to continue to provide business to AFL, but it chose not to. I am confident that had the production expectations been met, the actions of the regulator would not have influenced the continuing operation of AFL. It is too remote to suggest that the defendant's activities contributed to the union workers' inability, or desire, to meet production targets.

[457] As Matthew MacPherson observed, this was an atypical relationship, in that the employees of a for profit company would typically want the company to succeed in order that they benefit from its' success. In this case that did not hold true. Either the employees could not meet expectations, or did not want to meet expectations. In either case, their failures were not contributed to by the regulator.

CONCLUSION

[458] The action of the plaintiff has been unsuccessful, but the plaintiff had good reason to be troubled by some of the defendant's conduct in its' regulatory oversight of AFL.

[459] Though not tortious, the inspection activities of AFL were flawed in many ways.

[460] The Fire Marshall's office issued an order based on a erroneous understanding of the role of flashback arrestors in propane supply.

[461] The plant had very senior crane operators who had been allowed to work at DBC without an expression of concern by the regulator. When AFL took over, those same people, some with 20 to 30 years of crane operator experience, were forced to qualify under the **Stationary Engineers Act**, when the statute allowed them to be grandfathered. The Stationary Engineers Board of Examiners and the Minister refused to exercise discretion that was within their statutory authority and which could have certified the most obviously qualified. Had they done so a shutdown of the plant that was corrected by the Deputy Minister within 24 hours would have been avoided. This was particularly irritating for the plaintiff since the qualification - certification on the basis of motive horsepower - was largely unrelated to safe operation of the cranes and was dropped from the legislation a short time later.

[462] The OHSD inspector assigned to AFL lacked related experience and should have been under closer supervision. He was not following OHSD policies, or the general practice of the OHSD inspectors, with respect to the issuance of Notices

and Order of compliance. He recorded a gratuitous and unhelpful comment questioning the "fault finding" requirement of the JOHSC, without considering that the union had agreed to this regime in the Collective Agreement.

[463] There was no effort by even the most senior people in OHSD to ensure compliance with Section 17 of the **OHSA.**

[464] The decision to conduct a Joint Evaluation, while the correct one in all of the circumstances, was based on misleading and incorrect information provided unilaterally by the union. OHSD had access to all of the information necessary to ascertain the true state of the IRS at AFL, but they did not make those inquiries.

[465] Rigging orders were issued which could have created a competitive disadvantage to the plaintiff, and which may have included orders that were not applicable to the operation of the structural steel industry. That they were not later imposed on the industry speaks volumes about the Division's assessment of their necessity.

[466] I accept that the defendant's inspectors and their supervisors intended by their actions to ensure the safe operation of the plant, but there is no question that they failed on a number of occasions to give fair consideration and support to the plaintiff. While this did not contribute to the plaintiff's losses, one may reasonably suspect that this was in no small way attributable to the plaintiff's sometimes aggressive and sometimes seemingly unreasonable responses to regulatory action.

[467] While the action is dismissed, I am not prepared to make an award of costs against the plaintiff.

Dated at Halifax, Nova Scotia, this 21st day of December, 2009.

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Duncan J.