SUPREME COURT OF NOVA SCOTIA
Citation: *R. v. Hoyeck*, 2019 NSSC 7

Date: 20190111
Docket: CRH No. 464560
Registry: Halifax

Between:

Her Majesty the Queen

v.

Elie Phillip Hoyeck

D E C I S I O N

Judge:	The Honourable Justice James L. Chipman
Heard:	November 19, 20, 21, 22, 23, 26 and December 3, 2018
Oral Decision:	January 11, 2019
Written Decision:	January 11, 2019
Counsel:	Peter Craig, Q.C. and Alex Keaveny, on behalf of the Provincial Crown
	Trevor McGuigan, on behalf of Elie Phillip Hoyeck

By the Court (orally):

INTRODUCTION

[1] Elie Phillip Hoyeck stands charged that on or about September 20, 2013, at or near Dartmouth, Nova Scotia, did:

> (1) Being a person who undertook, or had the authority, to direct how another person did work or performed a task, fail to take reasonable steps to prevent bodily harm to that person, or any other person, arising from that work or task, and did thereby cause the death of Peter Dwight Kempton through criminal negligence, contrary to Section 220(b) of the Criminal Code.

[2] On the date in question, Mr. Kempton was working on a derelict Dodge Caravan at Mr. Hoyeck's Cole Harbour garage, Your Mechanic Auto Corner (Your Mechanic). While attempting to remove the vehicle's gasoline tank with an acetylene torch a fire ensued and Mr. Kempton sustained burns to ninety percent of his body. The next day, September 21, 2013, he died in hospital.

[3] The trial began before judge and jury and transitioned to a judge alone trial. After two days of evidence before the jury an issue arose when a juror wrote this note:

> I am wondering the background checking that goes into the jury <u>after</u> selection. I have noticed that Mr. Keavney [sic] has searched up myself on LinkedIn. In comparison to other jurors, some were also looked up, some were not. How do they choose who they search and who they do not? I understand social media is an open forum and that this information is available to anyone who wishes to retrieve it. I am wondering what information Mr. Keavney [sic] was looking for at the time of his search? I would maybe suggest searching in an "incognito" mode for future occasions. This does not make me feel like he overstepped, I just don't think it's appropriate for the crown to search with his name attached. We should not be made aware that he was looking into our backgrounds in that manner.
>
> [juror's underlining]

[4] After hearing from Crown and Defence counsel in response to the juror's concern, I adopted their joint recommendation to dismiss the jury and continue as a judge alone trial in keeping with the procedure outlined by Justice Cacchione in *R. v. Neil*, 2015 NSSC 67, at para. 8. In particular, counsel for the prosecution advised the Court that they were prepared to consent to re-election by the accused

to trial by judge alone. The next day, November 23, Mr. McGuigan filed the Notice of Re-election. On the same day, Crown counsel advised he wished to re-visit the authority for converting to a judge alone trial, ultimately providing the Court with these authorities:

1. *R. v. Oland*, 2018 NBQB [not released]
2. *R. v. Mehl*, 2017 BCSC 1769
3. *R. v. Scott*, 2014 BCCA 231
4. *R. v. MacLean*, 2002 NSSC 283
5. *R. v. Rowbotham*, [1994] 2 SCR 463
6. *R. v. Smith*, [1993] BCJ No. 1470

[5] Having regard to the authorities, I reviewed the situation giving rise to the re-election, adding:

> … that based on the reasoning in *Rowbotham* coupled with the more recent direction from the Supreme Court of Canada in *R. v. Jordan*, 2016 SCC 27 and *R. v. Cody*, 2017 SCC 31, I see the approach we adopted last week as an efficient common law procedure to deal with the situation. By way of just one example, it occurs to me that to have Mr. Spence re-testify before me would be not only inefficient but would cause undue burden on this witness. In the result, I am satisfied that the tenor of the Supreme Court of Canada's decisions is such that the form we chose may triumph over the formalistic approach of the earlier cases. Having said that I wish to state one important caveat, I am content to affirm the approach decided last Thursday morning provided I receive confirmation from both Crown and Defence counsel as well as Mr. Hoyeck that they are content with the solution.

[6] Following a short recess counsel and Mr. Hoyeck confirmed their collective wish to continue as a judge alone trial.

EVIDENCE

[7] The Crown called 11 witnesses and entered 23 exhibits, including four statements given by Mr. Hoyeck. The Defence elected not to call evidence. Of the Crown's witnesses, several were called to introduce the statements made by Mr. Hoyeck as follows:

Exhibit No.	Description	Date	Format	Approximate Length
7	Statement to police	2013-09-20	Video	30 minutes
8	Statement to the Nova Scotia Department of Labour and Advanced Education ("LAE")	2013-09-20	Audio	40 minutes
11	On-camera interview with the CBC	2014-09-16	Video	26 minutes
12	Statement to police (post-arrest)	2015-09-10	Video	1 hour, 15 minutes

[8] Three of the above statements were made to persons in authority (police and LAE) with the fourth provided to CBC news reporter, Elizabeth Chiu. Six of the Crown's witnesses – Constable Peter MacIntyre, Constable Derek MacFarlane, James Curry, Constable Ben MacLeod, John Chant, Paul Poirier and Corporal Joseph Allison – gave evidence providing context and /or introducing the statements in question. In the result, I will not summarize their testimony but rather repeat the background their evidence and the statements collectively establishes, set out in *R. v. Hoyeck*, 2018 NSSC 59, my *voir dire* decision admitting the statements:

> [5] On September 20, 2013, at approximately 11:50 a.m. an industrial accident occurred at Your Mechanic Auto Corner, a workplace located at 850 Main Street, Dartmouth. Your Mechanic Auto Corner was an auto body shop that provided auto service and repair. Mr. Hoyeck was an owner and the supervisor of the shop. Peter Dwight Kempton was a 58-year-old mechanic employed by Mr. Hoyeck.
>
> [6] On September 20, 2013, Mr. Hoyeck and Joseph Spence, another employee of the shop, went to the rear of the garage property and loaded a minivan on to a trailer. Mr. Hoyeck towed the trailer to the front of the property and backed the trailer into an area next to the garage bays and adjacent to a set of acetylene tanks. Mr. Kempton and Mr. Spence began to strip the van as it was going to be scrapped. While Mr. Kempton worked under the trailer, Mr. Spence began the process of removing the tires and other components from the minivan.
>
> [7] Mr. Kempton removed the catalytic converter using an acetylene torch without incident. As Mr. Kempton was using an acetylene torch to remove the steel straps that attached a gas tank to the minivan, the gas tank ignited with Mr. Kempton trapped under the vehicle.
>
> [8] At the time of the fire Mr. Hoyeck was working in the office of the garage. After hearing Mr. Spence calling for help he went to the minivan shortly after the

> fire began. After a few minutes Mr. Hoyeck and Mr. Spence were able to remove Mr. Kempton from under the minivan; however, it was too late. The fire caused Mr. Kempton to suffer severe burns to a significant part of his body. Mr. Kempton died of his injuries the next day.

Joseph Spence

[9] Mr. Spence was an important Crown witness, and he testified over the course of a day at the trial. He is 38 years old and has limited education. Mr. Spence presently is not working. His past jobs do not involve any in-depth safety training and he has no certificates.

[10] Mr. Spence has a criminal record dating back to 2005 including public mischief for lying to police. In January 2005 he was sentenced for this along with possession of stolen property and refusing the breathalyzer. He has been on the methadone program for almost 15 years. In September 2013 he was taking methadone and smoking cannabis daily.

[11] On September 20, 2013 Mr. Spence had been working for about two years at Mr. Hoyeck's garage doing a variety of small jobs. When Mr. Spence started at Your Mechanic, Mr. Kempton was working as a mechanic. Their boss was Mr. Hoyeck. By September 20, 2013 the business was pretty much packed up as Mr. Hoyeck's plan was to move the operation from Cole Harbour to Milford.

[12] Mr. Spence, Mr. Kempton and the other employees did not receive any courses or training while working for Mr. Hoyeck. At no time were they given protective equipment to wear. Mr. Spence and the other employees were paid with cash and did not receive T4 slips.

[13] Mr. Spence arrived at work around 10:00 a.m. on September 20, 2013. Mr. Kempton and Mr. Hoyeck were already there when he arrived. Mr. Kempton was working in one of the bays on a Jeep on a hoist. Mr. Spence said he and Mr. Hoyeck went to an area on the lot to get a van they were salvaging that day. They put the van on a "retired U-Haul trailer".

[14] Mr. Spence recalls Mr. Hoyeck drove the truck with the trailer behind it up to the front of the business. He described the lot as a mess with vehicles and boats "placed every which way" on the lot, which he likened to a maze. The van on the trailer was parked in front of the bay with the Jeep in it, perhaps 40'- 50' feet from the bay.

[15] Mr. Spence said he was given instructions from Mr. Hoyeck to take the battery and fuses out of the van. He added he was told to remove the tires and drain the oil or fluids. Mr. Kempton was given instructions from Mr. Hoyeck to take the catalytic converter and gas tank off the van. Mr. Spence said he was present when, "the way I remember it he was told to do it with an acetylene torch". Mr. Hoyeck did not say anything about emptying the gas tank or bleeding the line.

[16] Mr. Spence used vice grips and a four-way wrench or an air compressor to remove the wheel lug nuts. Mr. Hoyeck did not tell him what tools to use nor did he retrieve them for Mr. Spence. There were no written work procedures. He did not give Mr. Spence a deadline. Mr. Hoyeck was not around when Mr. Spence was working on the van.

[17] Mr. Spence gave two statements on September 20, 2013. The first was handwritten by a police officer and it was taken beginning at 1:30 p.m. and ending at 2:08 p.m. In answer to a question on re-direct examination about his state of mind at this time, he answered, "I probably should have been in hospital myself". The second statement was an audio statement to LAE personnel that was later transcribed.

[18] In the first statement Mr. Spence said nothing about Mr. Hoyeck telling Mr. Kempton to use a torch when removing the gas tank. In the second statement he agrees that he had been working on the van for roughly 30 - 40 minutes before Mr. Kempton came over to him. He says Mr. Kempton was told "to do these things today by Mr. Hoyeck".

[19] When Mr. Spence was taking off the tires, Mr. Kempton asked him to jack the van up a little higher so he could take the catalytic converter off. He believes he did this placing a piece of wood or jack to support the vehicle. At first, Mr. Spence did not recall acetylene and oxygen tanks in the area. Indeed, he could not be sure how they got there. He thinks he moved the tanks on their two-wheeled trolley.

[20] Mr. Spence does not recall seeing Mr. Kempton removing the catalytic converter but he knows he removed it. He described Mr. Kempton as "kind of scrunched down sitting on his bum on the back of his heels". Mr. Spence suggested to Mr. Kempton that he remove the gas tank from the driver's side of the van by putting this arm underneath and cutting. He thinks Mr. Kempton tried this but could not do it that way.

[21] Mr. Kempton got under the vehicle again. Mr. Hoyeck was not there and did not tell him to do this. Mr. Spence agrees tin snips or cutters were likely somewhere on the property. Mr. Hoyeck was not in the area when Mr. Kempton started to use the torch.

[22] Mr. Spence is not sure whether Mr. Kempton was working on the first or second strap holding the van's gas tank when the fire started. He had a wet rag to apply to the strap. He was using the acetylene torch, and "everything went quick".

[23] Mr. Spence estimates he was 3'- 4' feet away when the van blew up. It was complete chaos. He went between two of the bays and grabbed a fire extinguisher, but it did not work. He tried two or three more fire extinguishers, but none worked.

[24] Mr. Spence saw Mr. Hoyeck in the paint booth with his phone in his hand yelling. Mr. Spence told him to call 911 and Mr. Spence ran next door to the Dollar Store and called 911. He went back to the shop and could hear Mr. Kempton screaming. He was down by the tail of the trailer all the way under the trailer, on fire. Mr. Spence grabbed a raincoat and tried beating the flames off him. Next, Mr. Spence and Mr. Hoyeck picked Mr. Kempton up and moved him. Mr. Spence found a garden hose and put water on him. He placed his shirt on Mr. Kempton to cover his buttocks. An RN came over to attend to Mr. Kempton. Mr. Spence asked Mr. Kempton what happened, and he responded that he was not really sure. There could have been gas in the line, he really did not know. The ambulance soon showed up. The next day Mr. Spence learned at the hospital that Mr. Kempton died.

[25] In the past Mr. Spence recalled Mr. Hoyeck welding something under a vehicle and being asked by him to apply a wet rag. Mr. Spence did not do any welding at the shop. He did not know if a welding health and safety program was in place. He did not know if there was a flashback arrester on the torch. He understood the tanks did not explode.

EXPERT EVIDENCE

Captain Matthew Parker

[26] Cpt. Matthew Parker's *curriculum vitae* was entered as exhibit 3 and he was qualified as an expert as follows:

> Cause and origin of fire as well as identification and examination of fire burn patterns.

[27] Cpt. Parker is employed with Halifax Regional Fire and Emergency. During his career he has been a lead fire investigator 60 - 70 times. On September 20, 2013, he was the lead and George Evans was the secondary investigator. Exhibit 4, Cpt. Parker's Fire Investigation Report, was introduced and he went over his findings and conclusions. The last para. of his report reads as follows:

> Based on the examination of the fire scene, the fuel tank under the vehicle was the area of origin. The cause of the fire was determined to be as a result the use of a torch near the fuel tank. This was an accidental fire.

[28] Cpt. Parker was on the scene for about two hours and took about 40 photographs. He explained that the fire started on the exterior rear of the vehicle. He noted there was significant fire damage on the rear under carriage of the van. He was shown exhibits 6 and 6(a), and with reference to photo 36 said the fork in the middle of the photo is the remains of the torch. He said he could smell gas when he attended the scene shortly after the fire erupted.

[29] Consistent with his report, Cpt. Parker said the cause of the fire was accidental because there was no intent to set fire to the vehicle.

Staff Sergeant Royce MacRae

[30] S/Sgt Royce MacRae is with the RCMP H-Division Technological Crime Unit. His report was entered as exhibit 18. On March 28, 2018 he was provided with two photographs taken by Mr. Hoyeck on the day of the fire. He determined that both photos were taken on an iPhone 5. The first photo (which was entered as exhibit 2 and shows a view of the erupting fire at Your Mechanic) was taken by Mr. Hoyeck at 11:53 a.m. The second photo (which was not entered but variously described as a photo of Mr. Kempton after he was pulled from the fire) was taken at 11:56 a.m.

Dr. Marnie Wood

[31] Dr. Wood is a forensic pathologist and medical examiner with the Nova Scotia Medical Examiner service. Her *curriculum vitae* was entered as exhibit 13 and she was qualified as an expert:

> Capable of giving evidence as a medical doctor and pathologist with respect to cause and manner of death and injuries in humans.

[32] The Medical Examiner Certificate of Death (exhibit 14), Report of Post Mortem Examination (exhibit 15) and Report of Post Mortem Amendment (exhibit 16) were entered through Dr. Wood. She addressed the summary and cause/manner of death in her report:

> This 58 year old man was working under a car with a torch, when an explosion occurred. He was transported to hospital for treatment, but died the next day.
>
> Autopsy revealed thermal injury over a large area of the body, and evidence of treatment.
>
> Toxicology testing of antmortem [sic, antemortem] blood was positive only for morphine, which was given during medical treatment.

[33] Dr. Wood confirmed Mr. Kempton suffered a thermal injury with second and third degree burns over ninety percent of his body. With respect to toxicology, she said there was no alcohol in Mr. Kempton's blood from the sample taken in hospital before he died. Her report refers to the NMS Lab Report, addressed below.

Susan Crookham

[34] Ms. Crookham is a certifying scientist with NMS Labs in Pennsylvania. Her October 30, 2013 report was entered as exhibit 17. Other than morphine (which was used in hospital to treat Ms. Kempton), her report confirms:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Morphine - Free	31	Ng/mL	10	002 – Antemortem Blood	GC/MS

Other than the above findings, examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

According, there was no alcohol in Mr. Kempton's system when he died.

David Giles

[35] Mr. Giles has over thirty years in the field of automotive repair and related subjects. For the past ten years he has taught in this area at the Nova Scotia Community College (NSCC). His *curriculum vitae* was entered as exhibit 19 and he was qualified as an expert, as follows:

> The proper techniques for the service and repair of the mechanical and electrical systems of motor vehicles.

[36] Mr. Giles provided background with respect to the Red Seal Automotive Service Technician program, which he described as a Federal program. He noted that before receiving the designation, Red Seal mechanics are required to pass an inter-provincial exam. He had over 9600 hours in as an apprentice mechanic when he wrote the exam.

[37] On cross-examination Mr. Giles reviewed the training received by mechanics. He noted an apprentice qualifies to become a mechanic after 7200 hours of work in the field. Upon passing the exam, an individual is referred to as a Journeyperson or Red Seal mechanic. He agreed that whether a person is a technician or mechanic, they would have received training on removing a gas tank. Indeed, this is something he teaches at NSCC.

[38] Mr. Giles addressed what he termed a "toolbox talk", whereby employees and the shop owner meet daily to talk about what to expect during the day. He said the talks could be safety related and "probably half of the shops have some form of this". On cross-examination he agreed shop owners may not be involved in toolbox talks.

[39] Mr. Giles gave testimony with respect to hazard assessments and how, as an instructor, he emphasizes safety issues. He explained all of the aspects of personal protection equipment (PPE), ranging from safety boots to non-flammable, tear away uniforms. He explained that when working under a vehicle (on a hoist) with an acetylene torch that the following PPE should be used:

- goggles, safety glasses, a full face shield or a welding helmet with a dark shield;
- leather gloves; and
- non-flammable clothing, such as a smock or leather jacket.

[40] He noted that welding is typically done to repair an exhaust or patch a floor; i.e., to fuse metal together. Torches can be used to cut, but also grinders, reciprocating saws, pneumatic chisels, snips or cutters.

[41] Mr. Giles said he was asked to attend at 850 Main Street after the fire and attended there on September 24, 2013 where he met LAE officers Sterling Kendall

and John Chant (they interviewed Mr. Hoyeck on the day of the fire and the audio of the interview was played in Court – exhibit 8).

[42] Mr. Giles was tasked with assisting the officers and he led them on a walk through the site, focussing on the burned out 1998 Dodge Caravan. The walk through was videoed and two DVDs of the approximate 45 minute video were entered as exhibits 20 and 21.

[43] With the aid of exhibit 22, a sketch of the Caravan showing the proper jacking points, Mr. Giles explained how the derelict van was improperly raised on the trailer on the site. He demonstrated how the placement of the van on the U-Haul trailer made it prone to shifting and collapse.

[44] Mr. Giles explained the optimal way to deal with a salvage vehicle. His first choice would be placement of the vehicle on a hoist. If a hoist was not available, he would jack the vehicle on a concrete pad, placing safety stands under the vehicle at the proper points (per exhibit 22). In either scenario, a work hazard assessment would be embarked upon at the outset. Mr. Giles said he would "never" work under a vehicle while the vehicle wheels were being removed. Referring to photos of the Caravan as it existed at Your Mechanic, " there's no safe way to work", noting the lack of an escape route and, "you are absolutely not to use a torch in this confined space." Later he said in answer to a further direct-examination question about observing a person under a van with a torch, "I'd immediately stop and get him the heck out".

[45] When removing a gas tank Mr. Giles said the fuel lines and tank should initially be drained. Nevertheless, he noted empty tanks are still a risk as, "vapours are always a risk… you still have to be very careful with an empty tank". He recommended supporting the gas tank to be removed with a floor jack. As to using a torch, "absolutely never". Mr. Giles noted an acetylene torch burns at 5000 degrees and, "will melt or burn anything in its path". He similarly rejected the idea of using a wet rag in tandem with a torch.

[46] Mr. Giles described acetylene torches as being used typically for brazing, a form of welding. He described the gas, C_2H_2, as "very volatile" and that it is stored in "a special tank designed to deal with the gas". The oxygen (companion tank next to the C_2H_2) is under more pressure than normal as it is used as an accelerant. The tanks have a set of gauges on top designed to show the meter pressure. The two gauges are designed to be regulated. Check valves and regulators are required and sometimes flashback arresters are built into the valves.

The flashback arresters are required to prevent torch blow-back on the torch head so that flames are prevented from entering the tank. Flashback arresters can be placed between the hose and torch head but are not required in this location. Flashback arresters are required on the tanks.

[47] Mr. Giles testified there were no flashback arresters on the torch head or tanks. He characterized acetylene as, "a very dangerous gas". Mr. Giles did not find any tank safety caps, which were to be used during tank transport. He noted that the oxygen tank sitting on its own was, "a big concern… could be catastrophic… the tank should be separated and secured".

[48] Mr. Giles agreed that flashback arresters are not required on the barrel of a torch. In any event they are meant to prevent the reverse flow of flames so they do not go back into the supply line and tank. Mr. Giles did not examine the barrel handle. He said it is possible some torch handles have built in flashback arresters. He agreed flashback arresters do not function as check valves. Mr. Giles acknowledged the tanks did not rupture or explode in this case.

[49] From the witness stand, Mr. Giles narrated the video in great detail. He demonstrated the approximate place where the gas tank was located on the Caravan by drawing it on exhibit 22. He explained how the tank was held up by two straps and that each strap was bolted into the underside of the van. With the aid of the video and photographs he demonstrated how on the burned out frame there is one bolt still in the strap. Next, he showed how the other bolt from this strap was damaged. That is, the head of the bolt is missing, but the shank of the bolt is still in place. It was Mr. Giles' opinion that this bolt, "appears to be cut with a torch". The expert observed a hole in the gas tank remnant and thought that was, "possibly the point where the torch hit the tank".

[50] On cross-examination Mr. Giles acknowledged that based on his observations, one of the gas tank bolts would have been removed with a proper tool. He thought this could have been an air impact gun, air ratchet, hand ratchet or ratchet extension. He added that he observed an air impact gun at the scene. Mr. Giles also agreed that given that the second bolt was stripped or rusted, another type of tool should have been utilized to remove this bolt; i.e., one of the following:

- tin snips – a common tool, Mr. Giles did not search the shop to see if they were on site;

- reciprocating saw – he observed this at Your Mechanic;
- pneumatic saw; or
- hack saw

[51] Mr. Giles characterized all of these tools as "much safer options than the torch". He repeated that he would never use a torch to remove a gas tank. He also explained why it would be very inefficient and difficult to remove a catalytic converter with a torch.

[52] Mr. Giles noted an air impact or pneumatic gun could be used to remove the strap bolts. He added; however, that if the bolt was rusted an impact gun would probably strip it.

[53] He agreed gas tank removal is a common procedure as vehicles are regularly re-cycled and this involves gas tank removal. He added that removing a gas tank does not require a high level of skill and knowledge. Asked about the option of using a torch when encountering a stripped or rusted bolt, Mr. Giles responded, "absolutely not". He added that using a torch would not save time compared with going other routes, given the time required to get a torch ready and light it. In any event, Mr. Giles was firm in his resolve that, "in no scenario would it make sense to use a torch… the hazard assessment would not allow it".

[54] Mr. Giles provided detailed evidence with regard to the four fuel lines that would have gone in and out of the Caravan gas tank. On this vehicle the tank was 20 gallons and made out of plastic. The two straps were made of Boron, or reinforced steel.

[55] Mr. Giles said the way the van was raised was, "absolutely not in accordance" with industry practices or the Provincial curriculum. He noted that in addition to being precarious, the area was poorly lit and difficult to access. He added there was quite a bit of oil underneath the vehicle and on the frame and that, "oil can be flammable at a certain temperature when mixed with other chemicals and gas".

[56] Mr. Giles spent considerable time commenting on the general description of the yard at Your Mechanic pronouncing several falling and trip hazards as well as stability (with reference to the van placement) and fire hazards. He again touched on the dangerous storage of the oxygen tank. He spoke of, "a very congested yard… if something happens, accessibility, you can't get out or in".

[57] Inside Your Mechanic Mr. Giles noted similar concerns. For example, the hoist used for the Jeep did not have its safety latch cables attached. He described the lighting as "very limited" and noted trip, slip, fire and electrical hazards. In summary, Mr. Giles termed the garage, "absolutely unacceptable… this would be totally unacceptable, I've never seen a garage in this condition". Later he referred to the garage as being in "quite a state", when contrasted with the "good housekeeping" principles of a clean, neat and organized garage. He also talked about monthly safety meetings and ongoing WHIMS and occupational health and safety training, absent at Your Mechanic. Indeed, he characterized the business as being in disarray and, "I couldn't see it as operating as a motor vehicle business".

[58] Mr. Giles was referred to the *Occupational Safety General Regulations* (*OSGR*s) in force in Nova Scotia on September 20, 2013. In particular, he was referred to ss. 41, 109, 111 and 113, and the requirements not being in place at Your Mechanic. He was also referred to the *Canadian Standards Association* reference for safety in welding, cutting and allied processes (December, 2012 operative date). With reference to 4.2.1 (employer responsibility), 9.7.1 (Flashback arrestors), 11.1.1 (good housekeeping) and 11.2.1 (warning signs), Mr. Giles again addressed the inadequacies at Mr. Hoyeck's garage. On cross-examination he agreed the *OSGRs* do not speak to any situation where the torch removal of a gas tank is appropriate.

[59] With respect to the lighting, Mr. Giles agreed that the placement of the van made it problematic and that it would be, "very poor". He stated that the gas tank, undercarriage and gas lines were either dark or black in colour.

[60] On cross-examination, Mr. Giles agreed that if he was given a work order to remove a gas tank he would not need the owner, nor would he expect the owner to provide him with instructions on how to complete the task. In speaking about tasks assigned to a mechanic, he referred to the "right to refuse policy"; essentially meaning that if an employee is tasked with something he is not capable of or for which there are not the proper tools, he or she has the right to refuse to do the work.

Mr. Hoyeck's Statements

[61] Once again, the Crown introduced three statements provided to persons in authority by Mr. Hoyeck and one he provided to Ms. Chiu. In their closing submissions the Crown highlighted various portions of these statements asking the

Court to conclude Mr. Hoyeck directed that the work be done unsafely. I will address this and the other arguments in my analysis.

GOVERNING LAW

The *Criminal Code* R.S.C., 1985, c. C-46 Sections

[62] Sections 219 and 220 of the *Criminal Code* set out the offence of criminal negligence causing death:

> Criminal negligence
>
> 219(1) Every one is criminally negligent who
>
> (a) in doing anything, or
>
> (b) in omitting to do anything that it is his duty to do,
>
> shows wanton or reckless disregard for the lives or safety of other persons.
>
> Definition of duty
>
> (2) For the purposes of this section, duty means a duty imposed by law.
>
> Causing death by criminal negligence
>
> 220 Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable
>
> (a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and
>
> (b) in any other case, to imprisonment for life.

[63] In *R. v. Menezes*, 2002 CanLII 49654 (ONSC), Justice Hill dealt with criminal negligence causing death in the context of a street race. His thorough discussion of the applicable legal principles at paras. 72 – 78 is most helpful in my analysis.

[64] Section 217.1 results from an amendment to the *Criminal Code* (Act to amend the Criminal Code (criminal liability of organizations S.C., 2003, c. 21) and reads:

> Duty of persons directing work
>
> 217.1 Every one who undertakes, or has the authority, to direct how another person does work or performs a task is under a legal duty to take reasonable steps

> to prevent bodily harm to that person, or any other person, arising from that work or task.

[65] The objective of this legislation is to ensure the safety of employees within the workplace and to change the rules governing corporate liability. It was passed in response to the deaths of 26 miners as a result of the 1992 Plymouth, Nova Scotia Westray mine explosion.

[66] Section 217.1 does not create an offence but confirms the duty on everyone who is responsible for any work to take the necessary steps to ensure the safety of others. In *R. v. M.R.*, 2011 ONCA 190, Associate Chief Justice O'Connor noted at para. 25:

> 25 Section 220 of the *Criminal Code* creates the offence of criminal negligence causing death, and s. 221 creates the offence of criminal negligence causing bodily harm. The *Code* does not create an offence of criminal negligence simpliciter. A person is only liable for criminal negligence if the negligence causes either death or bodily harm.

He continued at paras. 28 – 30:

> 28 The test for criminal negligence as set out in s. 219 requires the Crown to show that an accused's conduct or omission represented a "marked and substantial departure" from the conduct of a reasonably prudent person in the circumstances. See for example, *R. v. J.F.*, [2008] 3 S.C.R. 215, at para. 9.
>
> 29 The high standard of a "marked and substantial departure" from the conduct of a reasonably prudent person applies to both the physical and mental elements of the offence: *R. v. J.L.* (2006), 204 C.C.C. (3d) 324 (Ont. C.A.), at para. 16. In addressing the offence of criminal negligence causing death, a court should first look to the *actus reus* of the offence and determine if the conduct or omission involved meets the marked and substantial departure standard. If it does, the court should then consider the question of whether the *mens rea* is established.
>
> 30 The mental element for criminal negligence is described as a modified objective test: *R. v. Hundal*, [1993] 1 S.C.R. 867, at p. 887, Cory J.; *R. v. Tutton*, [1989] 1 S.C.R. 1392, at p. 1413, McIntyre J. A court must consider the facts existing at the time in light of the accused's perception of those facts and assess whether the accused's conduct, in view of his or her perception of the facts, constituted a marked and substantial departure from what would be reasonable in the circumstances: see *R. v. Tutton*, at p. 1432. In considering this issue, the court should consider whether the accused either adverted to the risk involved and disregarded it, or failed to direct his or her mind to the risk and the need to take care at all. In most cases, the mental element can be inferred from the accused's conduct or omission: see *R. v. Creighton*, [1993] 3 S.C.R. 3, at pp. 73-74,

McLachlin J. (as she then was); *R. v. Hundal*, at p. 872, McLachlin J., concurring; *R. v. Tutton*, at p. 1432, McIntyre J.

Causation

[67] In *Menezes*, Justice Hill also reviewed causation and his analysis at paras. 91 to 93 bears repeating:

> 91 The starting point in the chain of causation which seeks to attribute the prohibited consequence to an act of the accused is usually an unlawful act in itself. When the commission of the unlawful act is with the relevant mental element for the crime charged, causation is generally not an issue.
>
> 92 The causation inquiry, other than in sentencing, is generally unconcerned with contributory negligence. As well, a wrongdoer cannot escape the thinskull rule - a wrongdoer must take the victim as found: *Nette v. The Queen, supra* at 518; *Creighton v. The Queen, supra* at 377-8. In examining the traceable origin of the chain of events causing death, remoteness may become an issue. If the act of the accused is too remote to have caused the result alleged, causation is not established. If the accused's actions are fairly viewed as only part of the history of the setting in which the prohibited result unfolded, without more, causation is not proven: *Regina v. Cribbin* (1994), 89 C.C.C. (3d) 67 (Ont. C.A.) at 80 per Arbour J.A. (as she then was). However, where the unlawful driving can be said to "still demonstrably influence the actual injury accident beyond serving as its backdrop", causation is established: *Regina v. F.(D.), supra* at 364.
>
> 93 Likewise, if the triggering of a chain of events is interrupted by an intervening cause, it can serve to distance and exonerate the accused from any responsibility for the consequence: *Nette v. The Queen, supra* at 507. Put differently, do independent factors exist which might reasonably be said to sever the link that ties the accused to the prohibited result? Or is the chain unbroken with the effect of the accused's actions subsisting up to the happening of the event or consequence? Is there a supervening cause such as to insulate the accused from the legal consequences flowing from the death? (*Regina v. Cribbin, supra* at 80).

[68] In determining whether a person can be held responsible for causing death, it must be determined whether the person caused death both in fact and in law. Factual causation demands an inquiry into how the victim came to his or her death, in a medical, mechanical or physical sense, and the contribution of the accused to the victim's death. Legal (imputable) causation is concerned with the question of whether the accused person should be held responsible in law for the death that occurred. See *R. v. Nette*, 2001 SCC 78, [2001] 3 S.C.R. 488, at paras. 44-45; *R. v. Shilon* (2006), 240 CCC (3d) 401, at para. 21 (Ont. C.A.).

[69] In *R. v. Kazenelson*, 2015 ONSC 36 (upheld on appeal; *R. v. Kazenelson*, 2018 ONCA 77) Justice MacDonnell discussed factual causation at para. 133:

> [133] Factual causation involves an inquiry into how the death or injury occurred in a medical, mechanical or physical sense, and with the contribution of the accused to that result. The question is generally resolved by asking whether 'but for' the conduct of the accused the death or bodily harm would have occurred: *R. v. Maybin*, [2012] 2 SCR 30, at paragraph 15; *R. v. J.S.R.*, 2008 ONCA 544, at paragraph 17.

He went on to review on legal causation at paras. 136 - 138:

> [136] One of the ways that legal causation narrows the field is by means of the doctrine of intervening acts. The doctrine recognizes that in some circumstances other causes may intervene in a way that would make it unfair to attribute responsibility for a resulting harm to the accused. In assessing whether it would be unfair, two approaches have emerged in case law.
>
> [137] The first approach looks to whether the intervening act was objectively or reasonably foreseeable. An intervening act that was reasonably foreseeable will not usually relieve the offender of responsibility, but an act that can be characterized as "extraordinary" or "unusual" might do so: *Maybin*, at paragraphs 30 – 31. The more difficult issue is determining what it is that has to be reasonably foreseeable. In *Maybin*, Justice Karakatsanis resolved that issue as follows:
>
> > [It] is the general nature of the intervening acts and the accompanying risk of harm that needs to be reasonably foreseeable. Legal causation does not require that the accused must objectively foresee the precise future consequences of their conduct. Nor does it assist in addressing moral culpability to require merely that the risk of some non-trivial bodily harm is reasonably foreseeable. Rather, the intervening acts and the ensuing non-trivial harm must be reasonably foreseeable in the sense that the acts and the harm that actually transpired flowed reasonably from the conduct of the appellants. If so, then the accused's actions may remain a significant contributing cause of death.
>
> [138] The second approach considers whether the accused's conduct was effectively overtaken by a more immediate causal action that was independent of the accused's conduct, making the intervening act the sole cause in law: *Maybin*, paragraphs 27, 46. For that to occur, the independence of the intervening act must be apparent. It must appear that the insofar as the harmful result is concerned, the conduct of the accused was "not operative at the time of the [harm]". "If the intervening act is a direct response or is directly linked to the [accused's] actions and does not be its nature overwhelm the original actions, then the [accused] cannot be said to be morally innocent of the [resulting harm]".

[70] Justice MacDonnell extensively relied on *R. v. Maybin*, 2012 SCC 24, the unanimous decision of Justice Karakatsanis. She addressed the issues of foreseeability and intervening acts related to causation at paras. 28 - 30 and 38:

> 28 Neither an unforeseeable intervening act nor an independent intervening act is necessarily a sufficient condition to *break* the chain of legal causation. Similarly, the fact that the intervening act was reasonably foreseeable, or was not an independent act, is not necessarily a sufficient condition to *establish* legal causation. Even in cases where it is alleged that an intervening act has interrupted the chain of legal causation, the causation test articulated in *Smithers* and confirmed in *Nelle* remains the same: Were the dangerous, unlawful acts of the accused a significant contributing cause of the victim's death?
>
> 29 Depending on the circumstances, assessments of foreseeability or independence may be more or less helpful in determining whether an accused's unlawful acts were still a *significant contributing* cause at the time of death. Any assessment of legal causation should maintain focus on whether the accused should be held legally responsible for the consequences of his actions, or whether holding the accused responsible for the death would amount to punishing a moral innocent,
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> 30 An intervening act that is reasonably foreseeable will usually not break or rupture the chain of causation so as to relieve the offender of legal responsibility for the unintended result. This approach posits that an accused who undertakes a dangerous act, and in so doing contributes to a death, should bear the risk that other foreseeable acts may intervene and contribute to that death. Because the issue is whether the actions and consequences were reasonably foreseeable prospectively, at the time of the accused's objectively dangerous and unlawful act, it accords with our notions of moral accountability. This approach addresses the question: Is it fair to attribute the resulting death to the initial actor?
>
> ...
>
> 38 For these reasons, I conclude that it is the general nature of the intervening acts and the accompanying risk of harm that needs to be reasonably foreseeable. Legal causation does not require that the accused must objectively foresee the precise future consequences of their conduct, Nor does it assist in addressing moral culpability to require merely that the risk of some non-trivial bodily harm is reasonably foreseeable. Rather, the intervening acts and the ensuing non-trivial harm must be reasonably foreseeable in the sense that the acts and the harm that actually transpired flowed reasonably from the conduct of the appellants. If so, then the accused's actions may remain a significant contributing cause of death.

[71] Justice Karakatsanis went on at para. 46 to note that, "whether the affects of an accused's actions are 'effectively overtaken by the more immediate causal action of another party acting independently' involves an assessment of the relative

weight of the causes, looking retrospectively from the death". She concludes her analysis by noting at para. 60, "[T]he dangerous and unlawful acts of the accused must be a significant cause of the victim's death".

POSITION OF THE PARTIES

Crown

[72] The Crown's theory is set out in paras. 4, 5 and 6 of their brief:

> 4. The conditions at 850 Main Street were chaotic and unsafe when Mr. Hoyeck parked the van and trailer amongst the chaos and directed Peter Kempton and Joseph Spence to prepare the van for salvage. In placing the van and trailer in the yard, Mr. Hoyeck created a work environment where Mr. Kempton and Mr. Spence were exposed to serious risk of bodily harm or death. Mr. Hoyeck then directed Mr. Kempton and Mr. Spence to engage in dangerous and risky work, taking no actions to manage the serious risks inherent in the work to be performed. To make matters worse, Mr. Hoyeck then ignored patently dangerous working conditions and work practices being performed before his own eyes.
>
> 5. In short, Mr. Hoyeck's conduct showed a total disregard for safety, and total failure to perform the duties he had pursuant to CC 217.1, the *Occupational Health and Safety Act* and applicable regulations, proper industry practice and common sense.
>
> 6. Mr. Hoyeck negligence was criminal, and his conduct cost Peter Kempton his life.

Defence

[73] The Defence responds as follows in his brief:

> 3. A significant legal issue in this case is causation. An analysis of allegedly negligent conduct by Mr. Hoyeck has no value unless it *caused* Mr. Kempton's death. An accused could conceivably be negligent in hundreds or thousands of ways, and potentially subject to consequences of any applicable legislation, but criminal liability pursuant to section 220(b) of the *Criminal Code* does not exist unless crown proves beyond a reasonable doubt that the negligence *caused* death.
>
> 4. The majority of the crown's arguments concerning Mr. Hoyeck's alleged negligence have no demonstrable causal nexus to Mr. Kempton's death and provide no assistance to the Court in determining whether Mr. Hoyeck is guilty of the charged offence. There are only two discrete and related factual issues to be resolved regarding Mr. Hoyeck's conduct that bear directly on the elements of the offence: did he specifically tell Mr. Kempton to use a torch to remove the gas

> tank; and/or was he aware that Mr. Kempton was going to use [a] torch to remove the gas tank. It will be argued that both questions must be answered in the negative. Finally, it will be argued Mr. Hoyeck reasonably believed that Mr. Kempton, a trained and experienced mechanic, knew how to carry out the task of removing the gas tank properly and safely, and had available to him the appropriate tools. Mr. Hoyeck did not fail to take reasonable steps, was not wanton or reckless vis-à-vis Mr. Kempton's decision to use the torch to remove the gas tank and must, therefore, be found not guilty.

ANALYSIS AND DISPOSITION

[74] Based on Mr. Giles' evidence, it is abundantly clear that Your Mechanic was in deplorable condition as at September 20, 2013. There were a myriad of safety issues and it can be fairly stated that the site presented an accident waiting to happen. Having made these observations, the task at hand is to focus on the charge before the Court and whether Mr. Hoyeck is beyond a reasonable doubt guilty of criminal negligence causing death. In doing so, I must focus on the manner in which Mr. Kempton died and whether Mr. Hoyeck's actions or omissions caused his death.

[75] From Dr. Wood's uncontroverted evidence, we know the cause of death was complications of thermal injury. The fire burned ninety percent of Mr. Kempton's body and he succumbed to his injuries the next day. From Cpt. Parker's unchallenged evidence we know the cause of the fire was determined to be as a result of the use of a torch near the fuel tank.

[76] Mr. Giles opined that under no circumstances should one remove a gas tank with torches. The obvious point is that placing an acetylene torch which burns at around 5000 degrees anywhere near gasoline liquid or vapour is fraught with risk. Gasoline liquid or vapour is of course highly flammable and the open flame of an acetylene torch anywhere near a gas tank is ill-advised because fire is the inexorable result.

[77] In recalling Mr. Spence's evidence, he said in his direct evidence that Mr. Hoyeck told Mr. Kempton to use the torch to remove the gas tank on the Caravan. In his statements, Mr. Hoyeck denies that he instructed Mr. Kempton in this manner. Having carefully reviewed all of the statement transcripts and watched the videos (and listened to the one that is audio only) twice in Court (on the *voir dire* and during the trial), I have great difficulty accepting much of anything Mr. Hoyeck said as being either reliable or credible. In this regard he gave largely

self-serving evidence and embellished his role in pulling Mr. Kempton from the fire. Mr. Hoyeck denigrated the deceased in his statements as at various points he referred to him as, "a drunk … an idiot … blind as a bat". Nevertheless, I must assess the totality of the evidence as it relates to the charge in question.

[78] The Crown relies on several passages from Mr. Hoyeck's statements in support of their position that he directed "Mr. Kempton and Mr. Spence to perform work in a needlessly dangerous manner that made the management of the risk needlessly impossible". In argument they have isolated the most harmful evidence given by Mr. Hoyeck and asked the Court to conclude that he directed that the work be done unsafely. With respect, given my review I fail to see any such direction coming from Mr. Hoyeck. At no point does Mr. Hoyeck say or suggest he knew Mr. Kempton was planning to use a torch to remove the gas tank. To the contrary, Mr. Hoyeck repeatedly says Mr. Kempton should not have used a torch.

[79] A year after the tragedy, when he is interviewed by Ms. Chiu he allows that he, stupidly, has removed a gas tank while working (on a vehicle) in his driveway. In my view, the admission is a long way from admitting that he directed or had any knowledge of Mr. Kempton using a torch to remove the Caravan gas tank. Similarly, in his statement two years after the event to Cpl. Allison, Mr. Hoyeck's words (see pp. 43 - 49) do not, in my view, come anywhere close to an acknowledgement that he saw Mr. Kempton do this previously.

[80] The Crown isolated a number of passages from Mr. Hoyeck's statements and interview in an attempt to demonstrate he must have instructed Mr. Kempton to use the torch and was in proximity to the vehicle a short time before the fire such that he must have know Mr. Kempton was going to use the torch. Having reviewed all of the evidence, I must reject the Crown's arguments. From my review of the evidence, I am of the view that the most that can be said is that Mr. Hoyeck walked by and greeted his workers at some point when they were in the vicinity of the van. There is nothing said by Mr. Hoyeck or Mr. Spence in acknowledgement of Mr. Hoyeck seeing the acetylene and oxygen tanks in proximity to the van. Further, Mr. Hoyeck does not admit to speaking with Mr. Kempton or Mr. Spence, other than to tell them to deal with the salvage of the van.

[81] Further, we know from what Mr. Hoyeck consistently said (as well as from Mr. Spence), that Mr. Hoyeck was in the Your Mechanic paint shop (away from the van) when the fire erupted. Finally, we have Mr. Spence's evidence of what

Mr. Kempton said when he was pulled from the fire and there is nothing said which points the finger at Mr. Hoyeck.

[82] Having synthesized all of the evidence I cannot conclude it was Mr. Hoyeck's instruction that caused Mr. Kempton to use the torch. Rather, I am drawn to the inference that Mr. Kempton must have acted on his own unwise impulse when he chose to fire up the acetylene torch in an attempt to remove the troublesome gas tank bolt. Afterall, we know from Mr. Giles' testimony that the first bolt on the second strap must have been taken off with a proper tool. Logically, then, it does not follow that Mr. Kempton was following Mr. Hoyeck's alleged instruction when he first went to work to take off the tank. I say "alleged" because the Crown has pointed to Mr. Spence's testimony in asserting that Mr. Hoyeck told Mr. Kempton to use the torch. On close scrutiny, I find this evidence to be lacking. For one thing, as was pointed out on cross-examination, when Mr. Spence was initially questioned by police after the incident, he said nothing about Mr. Hoyeck telling Mr. Kempton to remove the tank with a torch. Further, having regard to his otherwise coherent comments in his first statement, I do not accept the Crown's inference (from re-direct) that Mr. Spence must have overlooked this because he was too shaken-up. Additionally, I do not accept that because Mr. Spence told the LAE investigators (in his second statement on September 20, 2013) that Mr. Hoyeck told Mr. Kempton to use the torch that he must be believed. A contrary explanation may well have been that because he was concerned that they were questioning his involvement, he should implicate Mr. Hoyeck.

[83] I would add that even if I had found Mr. Hoyeck instructed Mr. Kempton to use the acetylene torch, given the totality evidence, the analysis cannot stop here. Once again, we know from Mr. Giles' evidence that Mr. Kempton did not initially use the acetylene torch when he went to remove the gas tank. Accordingly, even assuming he was told to do so by Mr. Hoyeck, he clearly did not initially heed the instruction. Rather, Mr. Giles testified that based on his examination of the underside of the burned out Caravan, Mr. Kempton must have successfully unscrewed one of the bolts attaching the gas tank strap to the frame of the vehicle.

[84] Given this evidence, I find that Mr. Kempton must have resorted to the acetylene torch only after first attempting to remove the straps by unscrewing the bolts. In the result, it is my finding that following an initial prudent (but ultimately unsuccessful) attempt to unscrew all of the bolts, Mr. Kempton then decided to attempt the removal with the acetylene torch. Given Mr. Giles' evidence, I am of the further view that Mr. Kempton chose this route instead of attempting to remove

the gas tank with other safe tools available at the shop; i.e., the various saws or tin snips.

[85] In addition to noting that the use of the acetylene torch in this circumstance is absolutely not the standard, I have also determined that it is neither an economical or efficient choice. In this regard it is not difficult to appreciate that using a saw or snips would be cheaper and quicker than taking the time to move the tanks to the site of the van and fire up and use the gas. When I consider this in the context of Mr. Hoyeck's statements and the state of his garage, I do not equate a likely more expensive and time consuming approach as his preferred option. Finally, in answer to the Crown's argument that Mr. Hoyeck said Mr. Kempton was too weak to use tin snips, I cannot accept this evidence any more than I can accept Mr. Hoyeck's other unfounded disparaging remarks about Mr. Kempton.

[86] In oral argument the Crown suggested causation was made out even without the instruction because of the confined space Mr. Kempton was forced to work in. Crown counsel referred to the van placement as a "death trap". When it was pointed out that Mr. Kempton obviously did not succumb because the van collapsed, the Crown responded by stating that once the fire erupted, Mr. Kempton was trapped and this is why he died.

[87] In my view, there is no evidence to support this theory. For example, nobody testified to Mr. Kempton being caught or trapped. There was no expert evidence suggesting that with a clear escape path, Mr. Kempton would have survived. Further, the photographs and evidence of all who were at the scene characterize an explosion; indeed, the Crown adopted the language of several of the witnesses who referred to this as an "explosion".

[88] In the result, I must conclude that the confined space and lack of an escape path had nothing to do with Mr. Kempton's death.

[89] The Crown appears to acknowledge Mr. Kempton was contributorily negligent as they address this at paras. 12 and 13 of their brief. In submitting "that any purported negligence on the part of Peter Kempton is neither a defence, nor an intervening act that would break the chain of causation attributable to the accused", the Crown relies on the *Kazenelson* decisions and Justice MacDonnell's comments at paras. 147 and 148 and the Ontario Court of Appeal decision (per Lauwers, J.A.) at paras. 15 and 16.

[90] In my view the situation in *Kazenelson* is readily distinguishable from the case before the Court. In *Kazenelson* workers went on a swing stage without fall arrest protection because the harnesses were not available. The accused, Mr. Kazenelson, did not ensure that there were nearly enough of the devices and the workers who were not wearing the life lines fell to their deaths. In contrast, the evidence here shows that proper tools were available to Mr. Kempton when he was in the process of removing the gas tank. Indeed, we know from Mr. Giles that Mr. Kempton started out by using a proper tool and after encountering difficulty with a bolt, chose to use the acetylene torch, when other safe tools were available.

[91] From my reading, Justice MacDonnell found Mr. Kazenelson guilty in large measure on account of him observing the workers without lifelines on the swing stage and then doing nothing to address it. On the facts of this case we clearly do not have an analogous situation. There is nothing to suggest Mr. Hoyeck observed Mr. Kempton with the torch in advance of his unfortunate death and then did nothing to address it.

[92] Based on all of the evidence I find that Mr. Hoyeck asked Mr. Kempton to remove the catalytic converter and gas tank without specifying any tools that must be used. Mr. Hoyeck did not go under the Caravan and was not present when Mr. Kempton went under the vehicle. From the evidence I conclude Mr. Kempton chose what tools to use when he went about removing the catalytic converter and in his attempt to remove the gas tank.

[93] There is no evidence to suggest Mr. Hoyeck knew Mr. Kempton was going to use a torch to remove the tank. Indeed, a logical inference is that Mr. Kempton only opted for the torch after he encountered the stripped bolt on the second strap. This was an unsafe procedure and Mr. Kempton, as a trained mechanic, should have known this. In my view, it would be unreasonable to suggest Mr. Hoyeck, an untrained mechanic / shop owner, should have supervised his employee, a Red Seal mechanic.

[94] In assessing Mr. Kempton's actions I am mindful of his qualifications as a Red Seal mechanic (as documented in exhibit 23). At the time of his death he was a 58 year old man with many years experience as a mechanic. Given all of the evidence, I must find that the tragedy that befell him was brought on by his own negligence. In my view it was Mr. Kempton's decision to use the acetylene torch in such close proximity to the Caravan gas tank that caused the fire, his injuries and resultant death. Based on all of the evidence it is impossible for me to

conclude beyond a reasonable doubt that Mr. Hoyeck did anything or omitted to do anything (that was his duty to do or not do) such that he is guilty of criminal negligence causing death. To pick up on the language from the Supreme Court of Canada, I find Mr. Hoyeck's actions were not a significant contributory cause of Mr. Kempton's death.

[95] Whereas the overall condition of Your Mechanic showed Mr. Hoyeck's wonton or reckless disregard for the lives or safety of other persons (and himself), I am not persuaded beyond a reasonable doubt that this was the cause of the death in question. In this regard, I have already touched on the unfortunate actions of Mr. Kempton in causing his own demise. I would add that on the totality of the evidence I am not convinced that the deplorable shape of the Your Mechanic premises caused Mr. Kempton's death. Whereas it may be fairly stated that Mr. Kempton was working in a very confined space with no clear exit paths, these facts do not impact on my overall conclusion. In this respect, I return to the experts' evidence. Mr. Giles testified that it was absolutely unsafe to carry out any work on the Caravan, precariously placed as it was on the U-Haul trailer. On top of this, based on Mr. Giles' testimony, Mr. Kempton could have invoked the right to refuse the work. In my view, Mr. Kempton should have moved the van to a safe spot before embarking on any work. In any event, Cpt. Parker testified that the cause of the fire was determined to be as a result of the use of the torch near the fuel tank.

[96] Given this evidence I am not persuaded that even if there had been a clear exit route from the Caravan that it would have made any difference to Mr. Kempton's unfortunate situation.

[97] The events unfolded largely without Mr. Hoyeck being in proximity as he was inside Your Mechanic in the paint shop area. He was not present when the tanks were moved to the vicinity of the van. Nor was Mr. Hoyeck by the van when Mr. Kempton fired up the torch and used it to remove the catalytic converter. Critically, Mr. Hoyeck was not present when Mr. Kempton decided to use the torch on the second strap in an attempt to remove the gas tank.

[98] Mr. Kempton died when a fire ignited. The fire caused his death. Mr. Kempton did not die on account of the chaotic, congested conditions at Your Mechanic. He did not die due to the van being unsafely lifted or positioned on the trailer. Mr. Kempton's death could not have been prevented by flashback arresters.

There is no evidence that non-flammable clothing would have prevented his death or that working fire extinguishers would have made any difference.

[99] Without question Your Mechanic was in a deplorable state as at September 20, 2013. The Crown's expert pointed to a litany of failures and I accept this unchallenged evidence. I would add that the photographs speak volumes as they show an unkept, embarrassingly messy property with multiple potential hazards.

[100] On top of this we have an accused who spoke ill of the dead in a disrespectful manner. Mr. Hoyeck's pejorative comments about Mr. Kempton are most unsettling and I can only imagine how they must affect Mr. Kempton's surviving family. Nevertheless, the task of the Court must be to consider the charge having regard to all of the evidence and the governing law.

[101] Given this, it is my determination that the Crown's case must fail. It is my finding that the Crown has failed to prove the critical element of causation. I am not convinced beyond a reasonable doubt of the guilt of Mr. Hoyeck. Mr. Hoyeck must be found not guilty.

Chipman, J.