REVIEW DECISION

Re: **Review Reference #: R0323627**
Board Decision under Review: April 16, 2024

Date: **February 18, 2025**

Review Officer: **Seeley Munro**

Introduction and Background

The employer was the prime contractor for a high rise with a multi-level underground parkade. An Occupational Hygiene Officer ("OHO") of the Workers' Compensation Board ("Board"), which operates as WorkSafeBC, inspected the employer's worksite on February 10 and February 13, 2024. This was in response to a February 8, 2024 telephone call from a worker complaining about safety concerns and a lack of response by the employer's management staff.

The Board issued two Inspection Reports ("IRs") to the employer. The first IR, dated February 13, 2024, was for violations of sections 4.3(1)(b)(i), 5.72 and 5.74 of the *Occupational Health and Safety Regulation* ("*Regulation*") and included a stop work order with respect to pressure washing and operating a blower inside the parkade. The second IR, dated February 14, 2024, was for violations of sections 5.38(2) and 13.4 of the *Regulation* and section 24(1) of the *Workers Compensation Act* ("*Act*").

In an April 16, 2024 order, the Board imposed an administrative penalty of $198,891.01 for the violations of sections 5.38(2) of the *Regulation* and 24(1) of the *Act*. The employer requests a review of the April 16, 2024 penalty and has provided lengthy written submissions and extensive materials in support of this request. The employer disputes the Board's reasons for issuing the penalty and says that the penalty is unjust. The employer asks that I rescind the penalty and instead issue a warning letter. In the alternative, the employer submits that the penalty should be calculated based on a location violation.

There are no other parties to this review. At the Review Division's request, the OHO who conducted the February 10 and February 14, 2024 inspections provided written comments, dated October 28, 2024. These comments were disclosed to the employer, who provided further submissions in response. The OHO then provided further clarifying comments, dated December 11, 2024. These were also disclosed to the employer, who provided an additional response.

Section 20(3) of the *Act* gives me the authority to conduct this review. Section 339(2) of the *Act* requires me to make a decision on the merits and justice of the case, applying the policies of the board of directors applicable in the case. The

policies are found in the *Prevention Manual*. The standard of proof that applies to this review is the balance of probabilities.

Preliminary Matter: Allegation of Bias

In its submissions in response to the OHO's October 28, 2024 comments, the employer indicates that the officer had a predetermined agenda when he arrived at the site to conduct his inspections in February 2024. To the extent that the employer is suggesting that the Board officer's conduct was prejudicial, it is important to note that allegations of bias are serious and should not be made without a foundation of supporting evidence.

I have considered the evidence and the employer's review submissions. I understand that the employer strongly disagrees with the Board's findings and decision and the evidence upon which they were based.

However, I note that aside from this disagreement, the employer has not provided any evidence to support a conclusion that the Board officer was prejudicial or biased in any way. Furthermore, in my review of the evidence I did not find anything that would support such a conclusion. Moreover, as a Review Officer I will make my own findings based on the submissions and evidence, and the relevant law and policy.

Issue

The issue under review is the Board's decision to impose an administrative penalty of $198,891.01 on the employer for violations of sections 5.38(2) of the *Regulation* and 24(1) of the *Act*.

Reasons and Decision

The Violations

Under section 95(1) of the *Act*, the Board has the authority to impose a penalty on an employer when the employer has failed to take sufficient precautions to prevent injuries, failed to comply with the *Regulation* or the *Act*, or has made an unsafe workplace. As noted, the Board imposed the administrative penalty under review as a result of the employer's contravention of sections 5.38(2) of the *Regulation* and 24(1) of the *Act*.

The employer did not request a review of the initiating violation orders. Therefore, I do not have jurisdiction to decide whether these orders should be canceled or confirmed, and these violation orders stand. However, to determine if a penalty is

warranted, I must first be satisfied there is a sufficient factual basis to support the imposition of a penalty.

As noted, the Board conducted the February 10 and February 13, 2024 inspections in response to a complaint from a worker about safety at the worksite, as documented in a February 8, 2024 Action Request. The name of the caller was redacted from the Action Request for privacy purposes. The employer made submissions speculating about the identity of the caller, which the OHO indicated in his December 11, 2024 clarifying comments was incorrect, and which the employer further disputed in response submissions.

While the complaint by an unknown worker might have prompted the inspections, it was merely a starting point. The OHO then conducted inspections of the worksite, speaking to various parties and taking photographs and notes of what he observed. Accordingly, the identity of the caller or the content of that call is of no particular relevance.

Rather, I will be considering the evidence obtained during these inspections, the OHO's comments and the employer's review submissions. I will then make my own determination as to whether the violations are supported, and a penalty is warranted.

1. Section 5.38(2) of the *Regulation*

Section 5.38(2) of the *Regulation* provides that a compressed gas cylinder must be secured to prevent falling or rolling during storage, transportation and use, and where practicable, must be kept in an upright position.

The February 14, 2024 IR indicates that the employer failed to secure several propane cylinders within the parkade and in the courtyard of the worksite, to prevent them from falling or rolling. The OHO stated that during his February 10, 2024 inspection, he observed several propane cylinders within the parkade and in the courtyard, which were not secured. The OHO confirmed that the employer had provided the propane cylinders for the worksite.

I note that the OHO took photos of the cylinders in both areas. The employer submits that some of the cylinders depicted in the photos were in fact secured using the interlock method, and that most of the cylinders were empty.

In his October 28, 2024 comments, the OHO acknowledged that some of the cylinders might have been secured, but that there were several more free-standing cylinders throughout the areas.

I have reviewed the photos the OHO took and note that they depict unsecured compressed gas cylinders, contrary to section 5.38(2) of the *Regulation*. Whether

some of these cylinders may have been empty, as the employer suggests, is irrelevant.

It is also irrelevant whether these were propane cylinders and thus constructed differently than other compressed gas cylinders, with different risks and industry-recognized modes of storage. The employer has provided lengthy submissions on this point, which it contends the OHO failed to address in his October 28, 2024 comments. However, I note that section 5.38(2) does not differentiate between types of compressed gas cylinders, and thus this is also immaterial to the applicability of this provision to the facts of this case.

I find the employer's violation of section 5.38(2) of the *Regulation* to be established on the evidence.

2. Section 24(1) of the *Act*

I now turn to the second violation. Section 24(1) of the *Act* requires a prime contractor to:

(a) ensure that the activities of employers, workers and other persons at the workplace relating to occupational health and safety are coordinated, and

(b) do everything that is reasonably practicable to establish and maintain a system or process that will ensure compliance with the *Act* and *Regulation*.

Section 24(1) is a general duty provision, and the employer must meet a standard of reasonableness.

To summarize, the initiating IR dated February 14, 2024 sets out the following reasons why the Board issued the section 24(1) order:

- Several unsecured propane cylinders at the worksite;
- A subcontractor's worker painting with inadequate protective equipment or ventilation, in the presence of other workers, and neither the employer nor the subcontractor could provide a safety data sheet or exposure control plan for the paint product;
- The employer's workers operating a gasoline-powered pressure washer and blower inside the underground parkade, contrary to the manufacturer's instructions; and
- All the manufactured wooden stepladders inspected at the worksite were not marked for the grade of material of their construction and their use (labels were all faded).

As noted, I have already addressed the propane cylinders, above. Regarding the rest of the bulleted items, I note that in addition to the February 13 and February

14, 2024 IR's, the Report for Administrative Penalty and the OHO's October 28, 2024 comments provide details about these other matters the OHO observed during the two February 2024 inspections, which led to the section 24(1) order.

The OHO noted that at the February 10, 2024 inspection, multiple subcontractors, such as painters and drywallers, were on site and various work activities were going on. The site superintendent ("B") was initially present but then left the site right before the OHO conducted a walk-through inspection. Y, the health and safety coordinator for the worksite (who also advised that she was the first aid attendant), accompanied the OHO during the inspection. My understanding is that a lot of the inspection took place in the parkade.

The employer questions Y's credibility and the reliability of the evidence she gave at and after the Board's February 2024 inspections. The employer submits that Y's statements to the OHO were incorrect and "appear to be in retaliation" to the employer.

It is unclear to me from the employer's submissions what Y was retaliating against, and I find this submission to be speculative. Moreover, I place significant weight on Y's evidence to the Board. I found Y's evidence to be consistent and supported by other evidence.

Painting

The OHO and Y initially met in the first aid room. Y said that the painting of traffic lines in the underground parkade was still underway, but (as it turns out, incorrectly) advised the OHO that the subcontractor for this work was not on site that day. Y was unable to provide the OHO with the safety data sheet or the exposure control plan for the traffic line painting, or any other documents for this sub-contractor (i.e., respirator fit test records, WHMIS training records, safe work procedures). Y and the OHO then left the first aid room and went to the underground parkade.

The OHO noted that areas on the first and second levels of the parkade had been cleaned and traffic lines had been painted, as there was red tape across to restrict access (presumably to allow the paint to dry). Y also pointed out a battery-powered traffic line painting machine on the second level of the parkade, and the OHO smelled fresh paint. Y advised the OHO that there was a functional mechanical exhaust ventilation system installed in the parkade, but the OHO noted that this system was not on during the inspection.

As the OHO and Y went to the third and fourth levels of the parkade, the OHO spoke with a worker ("Z"), whom Y explained was the principal of the line-painting subcontractor. Z was cleaning up and putting away materials. Z said he had been painting traffic lines in the parkade. The OHO noted that there were other employers' workers in the parkade at the time of the inspection.

Z confirmed that the exhaust ventilation system was not turned on at all that day and that stairwells from the parkade had not been sealed. The OHO discussed with Z the importance of the latter when painting, in order to prevent paint vapours from spreading throughout the building via the stairwells.

Z also said he had not worn any personal protective equipment (i.e., respirator, safety glasses, protective clothing or gloves) while he was painting. Z then retrieved from his truck a tight-fitting, half-face respirator. The OHO pointed out to Z that his full beard and moustache would interfere with the seal of the respirator and thus render it ineffective. Z was unable to provide the OHO with the respirator fit test record but said he had been fit-tested more than a year ago. A safety coordinator later gave the OHO Z's prior fit test record, dated December 28, 2022.

Like Y, Z was also unable to provide safety data sheets for the paint products. When asked, Y said she had not received safety data sheets or an exposure control plan from this subcontractor.

The employer submits that Y simply did not know how to find the documents the OHO had requested because she was new to the role. The employer advises that the painting subcontractor in fact had provided the employer with an environmental control plan (including use of the building ventilation system), a detailed hazard assessment and safety data sheets, which the employer reviewed and discussed before the work started.

It is significant to me that Z (a principal of the subcontractor) was unable to provide safety data sheets. While I acknowledge that Y might have been new to the role, the fact that she did not know how to locate these materials suggests that she was not adequately trained or supervised.

Although the employer may have had an exhaust ventilation system available, Y's and Z's evidence was that it was not used that day, nor did Z take other safety measures, when painting was clearly occurring. In addition, Y did not enforce with Z the requirement to use personal protective equipment.

This illustrates that the employer's overall system was inadequate to ensure that activities of employers and workers at the site were coordinated and in compliance with the *Act* and *Regulation*.

Gasoline Powered Pressure Washer and Blower

Y told the OHO that the assistant site superintendent ("X") had cleaned the parkade floors the day before with a gasoline-powered pressure washer and a gasoline-powered blower. Y said that the mechanical exhaust ventilation system was not turned on during the pressure washing or blowing. Y said that no

ventilation was provided during these activities until a subcontractor's worker complained about the exhaust from the gas-powered equipment. Even then, the exhaust ventilation system in the parkade was not turned on.

Rather, Y said that she set up four portable fans around the work areas in the parkade where the pressure washer and blower were being used. The OHO then explained to Y that the portable fans she had set up would not remove the exhaust fumes but instead would move the fumes to other areas.

I note that in a February 16, 2024 email exchange with the OHO, Y reiterated that on February 9, 2024, X and a worker "were pressure washing and using a blower (both gas powered)" on the second and third levels of the parkade without running the exhaust ventilation system.

Y took the OHO to a storage area and showed him the pressure washer and the blower, and the OHO took photos of both. I note that according to the warning label depicted in the photo of the pressure washer: "The engine emits toxic carbon monoxide. Do not run in an enclosed area. Read Owner's Manual before operation." The warning label on the blower has illustrations (i.e., pictograms), which the OHO explained depict inhalation hazards.

The OHO told Y that, as per its warning label, the pressure washer should not have been used in the parkade at all. Rather, the employer should have placed it outside and attached a long hose to wash the parkade floors. The OHO explained to Y that, due to the serious consequences of carbon monoxide exposures to multiple workers, he was issuing a stop work order for the pressure washing and use of the blower.

I find it troubling that Y was unaware of the warning label on the pressure washer or the fact that it should not have been used indoors. Indeed, the solution that Y told the OHO that she employed (i.e., setting up fans) only had the negative effect of moving the toxic fumes to other areas of the parkade.

The OHO returned to the site on February 13, 2024 to conduct a follow-up inspection, at which site superintendent B was now present, as was X and another health and safety coordinator ("J"). X confirmed to the OHO that he had indeed operated the gas-powered pressure washer inside the parkade, and that it was not until a worker of a subcontractor complained about his exposure to exhaust fumes that portable fans were set up.

Contrary to what Y told the OHO, X said he turned on the exhaust ventilation system. X showed the OHO an undated video of the portable fans and exhaust ventilation system. I question why X would have taken a video of these activities if he had thought what he was doing was in accordance with the *Act* and *Regulation*. Regardless, neither activity was helpful, as the manufacturer's label clearly indicated that the machine was not to be used indoors.

The employer submits that the portable fans and parkade exhaust ventilation system were available for any subcontractors to use. My understanding is that the employer is saying any failure to use such equipment is not the employer's responsibility. I am not persuaded by this argument. Section 24(1) of the *Act* explicitly requires the employer, as prime contractor, to coordinate the activities of all employers, workers and people at the worksite relating to occupational health and safety, and to do what is reasonably practicable to establish and maintain a process to ensure compliance with the *Act* and *Regulation* by the parties working at the worksite.

In any event, any measures X may have eventually taken in response to the complaint about the pressure washer (including turning on the exhaust ventilation system) were also inadequate. Indeed, the OHO also explained to B, X and J during this second inspection, as he had previously explained to Y, that the pressure washer should not have even been operated inside the parkade, as was clearly indicated on the warning label.

By doing so X exposed himself, the worker who was helping him, and any other workers in the parkade to the risk of toxic carbon monoxide. In addition, by operating the blower without proper ventilation and contrary to the manufacturer's instructions, X and any other worker operating the blower exposed themselves and any other workers present to a similar risk. This further demonstrates that the employer's overall system was inadequate to ensure that activities of employers and workers at the site were coordinated and in compliance with the *Act* and *Regulation*.

Ladders

In the parkade the OHO saw several manufactured stepladders set up and apparently being used. Of those, five wooden stepladders either had no labels or their labels were illegible, and thus the OHO could not determine the grade of the ladders or their appropriate use.

The OHO took a photo of one such ladder, and I note that it indeed depicts a faded, illegible label. The OHO issued an order, contained in the initiating February 14, 2024 IR, directing the employer to conduct a ladder audit. Upon doing so, X emailed the OHO with a photo of six additional manufactured ladders the employer had identified during the audit as non-compliant.

On review, the employer submits that the ladders in question with faded labels were, in fact, "of sound quality and condition." However, I note that this argument is directly contradicted by the evidence and even by the employer's own submissions. The employer does not dispute that there were ladders "that may have fallen outside of the requirements as set out in the [*Regulation*] relative to the condition of labeling." The employer submits that "however it is not

unreasonable that the assessment of such labelling differs from one individual to the next."

I am not persuaded by the latter argument. The ladders were not properly labelled, and others were subsequently identified by the employer as noncompliant. This also demonstrates a lack of adequate oversight by the employer in accordance with its obligations under section 24(1) of the *Act*.

Conclusion re: Section 24(1)

The employer has provided a copy of Y's Construction Safety Officer ("CSO") certification and submits that Y was given an orientation to her role by her manager. However, it is apparent to me from the OHO's evidence that whatever orientation Y received was inadequate.

The employer also acknowledges "that additional supervision here was necessary considering the outcome," it submits that "the deficiencies demonstrated by [X] were not widespread across the project." The employer advises that X was subsequently disciplined for his failures and was eventually fired following an investigation by the employer.

However, due diligence requires that specific steps be taken to prevent the contravention. What I am concerned with is the measures the employer had in place at the time of the violation, not any actions it might have taken after.

The employer submits that, considering the totality of the evidence, it is unreasonable to conclude that it was not duly diligent. The employer points out that in the year preceding the OHO's inspection, it had significantly improved its occupational health and safety program and describes "several significant initiatives."

I acknowledge that on review the employer has provided voluminous materials, including copies of its own internal inspection reports, organizational charts, job descriptions and performance evaluations for various safety staff and records of on-site meetings.

However, I conclude that the employer had inadequate procedures in place for important safety matters, as noted in the initiating February 14, 2024 IR and as discussed above and was not duly diligent with respect to section 24(1) of the *Act*. The employer, as prime contractor, failed to take all reasonable steps to both ensure that the activities of employers, workers and other people at the worksite related to occupational health and safety were coordinated, and also failed to do everything reasonably practicable to establish and maintain a system or process to ensure compliance with the *Act* and *Regulation*.

I find the employer's violation of section 24(1) of the *Act* is also established on the evidence.

As there is a sufficient factual basis to support the imposition of the penalty, the next questions before me are whether an administrative penalty is appropriate, and if so, the amount of the penalty

Criteria for Imposing Penalties

Under section 95(1) of the *Act*, the Board has the authority to impose a penalty on an employer when, among other things, the employer has failed to comply with the *Act*. In this case, the two violations have been established on the evidence.

As policy item P2-95-1, *Criteria for Imposing OHS Penalties*, explains, the Board must consider a penalty where at least one of the following applies:

- The violation resulted in a high risk of serious injury, serious illness or death;
- The employer previously violated the same, or substantially similar, sections of the *Act* or *Regulation*, or the violation involves failure to comply with a previous order within a reasonable time;
- The employer intentionally committed the violation;
- The employer violated a stop work order or a stop use order; or
- The Board considers that the circumstances warrant a penalty.

It is unnecessary that all of these factors are present before a penalty may be assessed. Only one is required.

In this case, the Board determined that the violations were high risk. Policy item P2-95-2, *High Risk Violations*, sets out how the Board determines whether a violation is high risk. A violation can be designated high risk, or the Board can determine that the circumstances are high risk, on the basis of the available evidence with respect to:

- The likelihood of an incident or exposure occurring; and
- The likely seriousness of any injury or illness that could result if that incident or exposure occurred.

The violations under section 5.38(2) of the *Regulation* and section 24(1) of the *Act* are not designated high risk. Guideline G-P2-95-2, *High risk violations*, provides guidance in determining whether a non-designated violation is high risk. This guideline states that the following should be considered:

> When considering the *likelihood of an incident or exposure occurring*, some factors to consider are:
>
> - The number of workers exposed;
> - The potential hazards that are present in the particular work or task being performed;
> - Whether the hazard has been effectively controlled (ineffective controls usually result in one or more violation orders under the *Regulation* or *Act*); and
> - The circumstances that increase the likelihood of a worker coming into contact with the hazard.
>
> When considering the *likely seriousness of any injury or illness*, some factors to consider are:
>
> - Whether, in circumstances where an incident or exposure occurs, any resulting injury or illness is likely to be serious or even fatal, due to the nature of the violation; and
> - Additional conditions or circumstances at the workplace that would increase the potential outcome of a serious injury, serious illness or death once a worker is exposed to the hazard.

Therefore, I must consider whether the circumstances in this case were high risk, based on the likelihood of an incident occurring and the likely seriousness of any injury that might occur.

As noted, as a result of the employer's violation of section 5.38(2) of the *Regulation* and its failure to effectively coordinate health and safety and ensure compliance with the *Act* and *Regulation* pursuant to section 24(1) of the *Act*:

- There were several unsecured propane cylinders in several different areas of the parkade, and the OHO noted they could easily fall or be knocked down and injure workers.
- Despite having an operational mechanical exhaust ventilation system for the parkade, Z painted traffic lines inside the parkade without using it. The OHO noted that the paint being used had flammable liquid components and that Z also reported using Xylene, a flammable liquid. The OHO indicated that the lack of ventilation meant that flammable vapours could have easily been ignited by, for example, Z's truck (which the OHO observed inside the parkade during the inspection) or any other equipment.

- The employer's own workers used a gas-powered pressure washer and blower indoors, contrary to the manufacturers' instructions, thus exposing anyone present to carbon monoxide and other toxic exhaust fumes.
- Ladders were improperly labeled such that their appropriate use in the construction context was unclear.

The OHO indicated, and I agree, that all of these incidents and exposures were highly likely and could have resulted in serious injury or death either by being struck by a propane cylinder, exposure to carbon monoxide, a fire or explosion (by the improperly vented paint and Xylene fumes or a fallen propane cylinder) or falls from ladders.

The employer disputes that an unsecured propane cylinder poses the level of risk that the OHO identified. I disagree and place weight on the OHO's evidence and conclusions. Regardless, even if this violation is not high risk, the section 24(1) violation is high risk on the facts.

Regarding the use of the gas-powered pressure washer, the employer insists that there was really only a minimal amount of indoor pressure washing and that Y's evidence is unreliable on this point. The employer further contends that the OHO's "assertion that workers were placed at risk of serious injury or death is disproportionate to the facts."

I am not persuaded by this submission. Any workers present on this large and busy worksite during those activities (pressure washing or use of the blower) would have been at high risk of serious injury. Indeed, Y advised the OHO that a young worker in fact complained about the exhaust fumes from the pressure washer.

Accordingly, I am satisfied that there was a high risk violation in this case. Therefore, an administrative penalty must be considered.

Due Diligence

Section 95(3) of the *Act* indicates that the Board must not impose an administrative penalty if the employer exercised due diligence to prevent the failure or non-compliance to which the penalty relates.

Policy P2-95-9, *OHS Penalties – Due Diligence*, explains that an employer acts with due diligence where the employer shows, on a balance of probabilities, that it took all reasonable care to prevent the failure, non-compliance, or conditions to which the penalty relates. This involves considering what a reasonable person would have done in the circumstances. Due diligence will also be found if an employer reasonably believed in a mistaken set of facts which, if true, would render the act or omission innocent.

I have already considered due diligence in my discussion of the violation of section 24(1) of the *Act*. I found that the employer did not take reasonable steps to prevent that violation.

Indeed, it is troubling to me that following the February 10, 2024 inspection, in a February 12, 2024 email, site superintendent B provided the OHO with a "[v]entilation plan" for power washing the first level of the parkade and advised that they would close a stair "and use it as an exhaust."

In an email response that same day, the OHO told B not to pressure wash in the parkade yet, and further explained (as he had explained to Y) that, "as per the manufacturer's instructions" (which, as noted, are clearly indicated on a warning label on the pressure washer) the employer could not use the pressure washer inside the parkade, or at all indoors. The OHO also reminded B that if they used that pressure washer in the parkade the employer would be violating a stop work order.

For the reasons that follow, I also find that the employer did not take reasonable steps to prevent the violation of section 5.38(2) of the *Regulation*. In that regard, the OHO pointed out that an email to subcontractors required all propane cylinders be removed from the parkade by January 13, 2024.

I have reviewed the email the OHO referenced, which I note was from site superintendent B on January 10, 2024 and indicated that "[e]veryone is expected to remove propane from parkade by end of January 13th." With this email, B also forwarded an earlier email from assistant site superintendent X that same day, in which X asked that all forklift propane tanks be removed from the parkade and expressly stated:

> …Please ensure all tanks are tied and you have no smoking signs. Feel free to contact me with any questions or concerns. I can help you coordinate storage areas.

As noted, the OHO observed several unsecured propane cylinders throughout the parkade during his February 10, 2024 inspection. The employer submits that the employer was in the process of removing these cylinders and that "dozens" of such cylinders were being used for heating because it was winter. My understanding is that the employer submits it is reasonable for propane tanks to be "demobilizing continuously through the winter months," given the size of the project. However, in their submissions the employer concedes that its "practice for the storage of these cylinders inside the parkade at the [worksite] required more care and attention such that a regulatory shortfall was identified."

I agree with the OHO that the January 10, 2024 email and the OHO's subsequent observation of the unsecured propane tanks nearly a month later

suggests an inadequate follow up by the employer to ensure that this "deficiency was actually corrected."

I conclude that the employer did not take all reasonable care and was not duly diligent in preventing the section 24(1) and 5.38(2) violations. I will next consider whether a penalty should be imposed.

Additional Factors in Deciding Whether to Impose a Penalty

Policy item P2-95-1 also sets out three additional factors that must be considered with regard to imposing a penalty:

- The potential for serious injury, illness or death in the circumstances, based on the available information at the time of the violation;

- The likelihood that the penalty will motivate the employer and other employers to comply in the future, taking into account one or more of the following:

    a) The extent to which the employer was or should have been aware of the hazard;
    b) The extent to which the employer was or should have been aware that the *Act* or *Regulation* were being violated;
    c) The compliance history of the employer;
    d) The effectiveness of the employer's overall approach to managing health and safety; and
    e) Whether other enforcement tools would be more appropriate.

- Any other relevant circumstances.

I have already determined that the penalties in this case are for violations with a high risk of serious injury or death, which strongly supports the imposition of a penalty.

Furthermore, it is clear to me from the OHO's evidence and the employer's inspection and violation history leading up to the February 10 and February 13, 2024 inspections that the employer was or should have been aware of the hazards and violations in this case, as the prime contractor of the worksite.

The employer contends that its prior violations "were materially different" than the violations that are the subject of this penalty. Having considered the violation history, I reach a different conclusion.

I note that there are three prior orders to the employer under section 24(1) of the *Act*. In particular, following an October 2021 inspection, a Board officer issued such an order to the employer. A year later, following an October 2022

inspection, the Board again issued orders to the employer, including under section 24(1), and then imposed an administrative warning as a result of these violations. A few months after that, after a July 2023 inspection, the Board again issued orders to the employer, including a stop work order and a section 24(1) order.

There are also two prior orders to the employer under section 5.38(2) of the *Regulation*. Specifically, after a February 2020 inspection, the Board issued orders to the employer, including under section 5.38(2). Following a March 2022 inspection, the Board issued a section 5.38(2) order. Both of these prior orders pertained to improper storage of compressed gas (propane) cylinders.

As the OHO points out, the employer has been operating for nearly 30 years. In my view, these multiple prior inspections, violations and warning, along with the employer's years of experience, demonstrate to that it should have been aware of the requirements of the *Act* and *Regulation*.

However, given what the OHO observed on February 10 and 13, 2024 and the nature of the repeated violations in this case (including under section 24(1) of the *Act* which, as noted is a general duty provision), it is clear to me that the employer's overall approach to health and safety is ineffective.

The employer submits that a warning letter is more appropriate than an administrative penalty. In that regard, policy item P2-95-10, *OHS Penalty Warning Letters,* states that the Board may send warning letters when the grounds for considering an administrative penalty are met and an employer has failed to exercise due diligence. This policy provides factors for considering the appropriateness of a warning letter. A key factor is the likelihood that the warning letter will be sufficient to motivate the employer to comply in the future. Another is the potential for serious injury, illness, or death in the circumstances.

Given the employer's years of experience, its prior violation history, my finding that the violations were high risk, in conjunction with the fact that it was previously given a warning for a section 24(1) violation, I find that an administrative penalty is the most appropriate means to encourage the employer, and other employers, to comply with its obligations under the *Act* and *Regulation* in the future.

Therefore, for all these reasons, as well as the findings I have made regarding the employer's lack of due diligence in this case, I am satisfied that enforcement tools short of a penalty are inappropriate. A penalty is necessary to motivate this employer, and other employers, to comply in the future.

The Penalty Amount

Policy P2-95-5, *OHS Penalty Amounts*, sets out how a penalty is calculated, and involves several steps. The first step is to take 0.5% of the employer's "penalty payroll," subject to a minimum of $1,250 and a maximum of half the statutory maximum. The "penalty payroll" is the employer's assessable payroll for the full calendar year immediately preceding the year in which the incident giving rise to the penalty occurred. In this case, the Board determined that initial amount was $99,445.51, based on the employer's payroll.

Location Violation

The policy allows for a penalty to be calculated using a smaller payroll, if the violation was a location violation.

Policy P2-95-5 states that where a firm as more than one permanent location or is divisionally registered, the Board will determine the penalty payroll based on the lowest applicable amount of the following where the violation occurred:

(i) fixed location,
(ii) division, or
(iii) classification unit,

if the employer promptly provides sufficient evidence to establish that, at the time of the violation, it was doing all of the following at the applicable location, classification or divisional level:

a) effectively communicating with all locations regarding health and safety concerns,
b) providing adequate training to managers and others who implement site health and safety programs,
c) making local management accountable for health and safety, and
d) providing local management with sufficient resources for health and safety.

The employer submits that if a penalty must be assessed, it should be assessed as a location violation, based on payroll for the specific location at which the incident occurred, rather than its entire payroll.

However, as the OHO points out in his October 28, 2024 comments, the employer only has one permanent (fixed) location and is not divisionally registered. The worksite that was inspected is not a permanent worksite and the employer no longer operates at the site. The employer has not provided evidence to dispute that this is the case, and I accept the OHO's evidence on these points.

Accordingly, I confirm that the violations in this case do not meet the criteria set out in the policy to be considered location violations. Therefore, the employer's entire payroll will be used in calculating this penalty.

Multipliers

Item 2(b) of the policy provides for the application of multipliers. The Board determined that the multiplier for a high risk violation applied, and therefore multiplied the initial amount by two, resulting in $198,891.01. As set out above, I agree that the section 24(1) and section 5.38(2) violations were high risk, so this multiplier is in accordance with policy.

Variation Factors

Policy P2-95-5 also provides that variation factors should be considered. In exceptional circumstances only, a penalty may be reduced or increased by up to 30%. In this case, the Board did not find any exceptional circumstances to warrant reducing or increasing the amount of the penalty.

In this case, the Board did not find any exceptional circumstances to warrant reducing or increasing the amount of the penalty. The employer did not provide any submissions directly in support of varying the penalty. Thus, I find there are no exceptional circumstances that warrant reducing the amount of the penalty in this case and that no variation factors are applicable.

As such, I conclude that the penalty of $198,891.01 was appropriately calculated in accordance with the policy. As a result, I deny the employer's request.

Conclusion

As a result of this review, I confirm the Board's April 16, 2024 order.

Seeley Munro (She, Her, Hers)
Review Officer
Review Division