REVIEW DECISION

Re: **Review Reference #: R0329332**
Board Decision under Review: September 13, 2024

Date: **April 25, 2025**

Review Officer: **Carmen Dowhaniuk**

Introduction and Background

The employer was the prime contractor for a construction project. On September 15, 2022, a worker of a sub-contractor was injured when a fire occurred while he was working in a confined space. Following this incident, an officer of the Workers' Compensation Board ("Board"), which operates as WorkSafeBC, inspected the worksite that same day. The Board subsequently issued a March 5, 2024 inspection report, citing the employer for violations of section 9.12 of the *Occupational Health and Safety Regulation* ("*Regulation*"), and section 24(1) of the *Workers Compensation Act* ("*Act*").

In the September 13, 2024 decision under review, the Board imposed an administrative penalty of $43,590.18 against the employer. The penalty order was based on a violation of section 9.12 of the *Regulation* and section 24(1) of the *Act*.

The employer has requested a review of the penalty order and has provided submissions in support of its request.

The Board officer provided comments at the request of the Review Division. These were disclosed to the employer, which did not provide further submissions.

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's 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.

Issue

The issue is the Board's order imposing an administrative penalty against the employer.

Preliminary Matters

In its submissions, the employer has raised concerns with how the Board investigated the September 15, 2022 incident and with other inspection reports

issued to it. The employer has also asked that references to an explosion in the Report for Administrative Penalty ("RAP") be removed.

Item A2.1.1 of the Review Division's *Practices and Procedures* provides that the Review Division's jurisdiction is limited to decisions in a specific case. In addition, the right of review is restricted to decisions that affect a person's entitlement to a benefit or impose an obligation or responsibility. It does not cover incidental decision or actions of an administrative matter. Accordingly, I have no authority to address how the Board investigated the incident, other inspection reports, or the language used in the Board's documents. My jurisdiction is limited to the Board's September 13, 2024 decision to impose an administrative penalty on the employer for violations of section 9.12 of the *Regulation* and section 24(1) of the *Act*.

Reasons and Decision

The Violations

The employer did not request a review of the violation orders that the September 13, 2024 penalty was based upon, and I therefore do not have the authority to confirm or cancel these orders. However, in order to determine if a penalty is warranted, I must consider whether the underlying facts support the imposition of a penalty.

As set out in the RAP, the employer hired a roofing and waterproofing sub-contractor to work on a water feature at a construction project. On September 15, 2022, one of the workers of a sub-contactor applied primer and a waterproof membrane to the interior of a water surge tank and then used an open-flame torch to seal the membrane. The water surge tank was a rectangular concrete box with an open top which met the definition of a confined space, and it was located in the water feature mechanical room. The worker climbed into the tank to apply the primer and when he later returned to seal the membrane, he stood on a pipe on the outside of the tank, leaned forward and turned on the torch. The torch caused vapours from the primer to ignite, and the worker was injured in the resulting fire.

<u>Section 9.12 of the *Regulation*</u>

Section 9.12 of the *Regulation* addresses the identification of confined spaces. It provides that when a confined space requires entry by a worker, each point of access which is not secured against entry must be identified by a sign or other effective means which indicates the hazard and prohibits entry by unauthorized workers.

The RAP indicates that a worker of the employer identified the water surge tank as a confined space and posted a sign on the door of the mechanical room which

stated “Confined space. Do not enter.” The Board officer determined that there was a violation of section 9.12 because in posting a sign on the mechanical room door, it was unclear that the tank was the confined space.

The employer submits that in addition to the sign on the door, there was also a second sign on the wall of the tank itself and it has provided a copy of a photo of that sign which was reportedly taken by a safety consultant on the incident date. As the photo provided in the submissions is small and of extremely poor quality, I am unable to determine exactly where this sign was posted.

However, a picture taken by a Board officer during the inspection, and included in the RAP (figure 2), shows that there was a sign on the floor in front of the tank. I was able to zoom in on that sign and it read “Confined Space. Do not enter.”

The employer has also referred to the transcripts of Board interviews with workers at the construction site. During an interview with the site superintendent, a Board officer noted that one of the signs they had seen during the inspection appeared to have fallen off, and there was another sign on the door. The site superintendent advised that the sign on the floor may have been on the tank wall and safety officer X could confirm that. The site superintendent stated that he was unsure why a sign was on the room door, but there had been a sign “over by the tank” identifying it as the confined space and not the room.

In the interview with safety officer X, she advised that following the incident, she did not see the sign she had previously posted on the wall of the tank identifying it as a confined space. A Board officer advised X that when she had attended the scene for the inspection, she saw a sign on the floor as well as a sign on the door. This evidence from X and the Board officer supports that there was a second sign.

The presence of a second sign was not referred to in either the inspection report or in the RAP. However, based on the Board’s photo and the above interviews, I am satisfied that, in addition to the sign on the door, there was a second sign which had been posted on the wall of the tank identifying it as a confined space. This second sign appears to have fallen onto the floor in front of the tank, and it is unclear if that occurred prior to the workplace incident or afterwards.

Although there is no evidence as to when or why this sign may have fallen off the wall, I conclude that the confined space in question had been identified with a sign which indicated the hazard and prohibited entry. There was therefore no violation of section 9.12 of the *Regulation*.

Section 24(1) of the *Act*

Section 24(1) of the *Act* addresses coordination at multiple-employer workplaces. It provides that the prime contractor of a multiple-employer workplace must:

(a) Ensure that the activities of employer, 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 occupational health and safety provisions and the regulations in respect of the workplace.

Section 24(1) is a general duty provision, and the standard for the employer to meet is that of reasonableness. This means that the employer must have acted with due diligence to prevent the violation.

In the RAP, the Board officer determined that there had been a violation of this section because the employer did not: establish and maintain a system to ensure that work was done safely and compliant with the *Regulation*, ensure that safe work procedures were established for all high risk tasks, ensure that the sub-contractor had established confined space entry protocols and adhered to the *Regulation* and *Act*, ensure that the confined space was properly identified, and did not adequately coordinate the sub-contractors work with regard to the occupational health and safety provisions.

I have already determined that the confined space had been properly identified. In considering the other factors noted by the Board, I am satisfied that the employer acted with due diligence to prevent the violation.

In its submissions, the employer advises that it had informed the sub-contractor that the surge tank was ready to be worked on. The sub-contractor then had approximately 30 days to have a safety consultant develop safe work procedures prior to beginning the work, but it failed to do so. As only the sub-contractor's workers would enter the confined space, the employer submits that it was the sub-contractor's responsibility to assess the risks associated with working in that space and to develop safe work procedures.

The employer further submits that the sub-contractor did not inform them that its workers would be working in the confined space on the day of the incident. The transcript of the Board interview with the employer's site superintendent indicates that sub-contractors were expected to report to a safety officer when they come on site and advise of the work that they would perform that day. If needed, the sub-contractor was expected to work with the safety officer to complete a hazard assessment of their work and provide her with any needed permits such as a

permit to do “hot work.” I understand the reference to “hot work” to mean using an open flame torch as the worker did in this case.

The Board’s interview with safety officer X indicated that neither the sub-contractor, nor the injured worker, had advised her that they were working on site that day and she therefore did not receive any hazard assessment or permit from them.

While the employer submits that the sub-contractor had around 30 days to develop safe work procedures, that timeline is not consistent with information from the sub-contractor itself. The Board interviewed Y, a co-owner and supervisor of the sub-contractor, and he stated that the employer had told him approximately one month prior to the incident that the tank was ready to be worked on. According to Y, they had no immediate intention to work in the confined space as there was more important tasks to complete. Work inside the tank could occur a year from the time the employer had advised that the tank was ready to be worked on. As there was no plan to work inside the tank, Y did not inform the employer that any workers from the sub-contractor would be on site that day.

Y indicated that he had instructed the worker to apply primer to the tank, but he did not instruct or expect him to use a torch. Y stated that he completed hazard assessments all the time on behalf of the sub-contractor which he would leave at the employer’s safety trailer. In order to perform work in the tank, Y advised that the process was to have his safety consultant, Z, write a specific field level hazard assessment for the confined space. The interview with the employer’s site superintendent also confirmed that the sub-contractor had been told that it had to prepare a hazard assessment and safe work procedures before working in a confined space. I am therefore satisfied that the employer had informed the sub-contractor of the need to assess the hazards and develop safe work procedures for the confined space.

In discussing why, a hazard assessment had not been completed for working in the tank, Y provided several reasons. He advised that he did not complete a hazard assessment because he did not intend for work to be done inside the tank on that day. He also said that an assessment was not completed because it was the end of the project. In addition, he was elsewhere on that day, and the assessment would have been done when he returned. Y stated that things “got out of hand.”

The above evidence supports that the employer had a system in place to ensure that work was done safely and that the activities of persons at the workplace relating to health and safety were coordinated. Specifically, the employer expected any sub-contractor that came on site to report to its safety officer and to inform them of what work they would be doing that day. If a hazard assessment was needed, that documentation was to be provided to the safety officer before

work began. The sub-contractor co-owner and supervisor indicated that he was aware of these procedures and requirements, but he and his worker did not follow them on the day in question.

In addition, if there was no specific timeline for the sub-contractor to complete work inside the water tank, as stated by Y, then there would be no reason for the employer, as prime contractor, to have been coordinating with the sub-contractor on that work. The employer expected a hazard assessment to be provided by the sub-contractor before it began work in the confined space, but since no assessment had been provided, the employer would not have expected work to have begun in that space.

Since the sub-contractor and its worker did not follow the employer's systems and procedures, the employer could not have reasonably foreseen that the worker would have been working in the confined space in violation of confined space requirements.

In my view, the employer took reasonable steps to prevent the violation. As the prime contractor, the employer had systems and procedures in place to ensure that sub-contractors had safety protocols to perform their work. It is the responsibility of the sub-contractor and its workers to follow those safety protocols. That the sub-contractor and its worker did not in this case does not by itself support a lack of coordination by the employer or a failure to have a system or process in place to ensure compliance.

I am satisfied that the employer acted with due diligence, and therefore find that the evidence does not support a violation of section 24(1) of the *Act*.

As neither violation on which the Board based the penalty has been established, there is no basis for imposing a penalty. The administrative penalty order is therefore cancelled.

As a result, I allow the employer's request.

Conclusion

As a result of this review, I cancel the Board's penalty order of September 13, 2024.

Carmen Dowhaniuk
Review Officer
Review Division