
To inquire into . . .

(c) whether any neglect caused or contributed to the occurrence;

(f) whether there was compliance with applicable statutes, regulations, orders, rules, or directions

The Department of Labour shares with the Department of Natural Resources the responsibility for failure to coordinate the several aspects of mine regulation. We have reviewed the claims of the Department of Natural Resources concerning its duty to regulate for safety and for compliance with approved mine plans.¹ The Department of Labour was responsible for regulating occupational health and safety at the mine and as such was the body most responsible for the exercise of regulatory authority with regard to safe mining at Westray.² Aspects of the department's performance have been discussed as appropriate elsewhere in this Report, particularly in Chapters 4, 5, 7, and 9, Training, Working Underground at Westray, Ventilation, and Dust.

During the public hearings, the Inquiry heard evidence from many witnesses that related to the responsibilities of the Department of Labour. The nature of the evidence and testimony surrounding the performance of the Department of Labour personnel has made it difficult to tell this part of the Westray story in as straightforward a manner as was possible for much of this Report. Their story is lamentably easy to summarize – poor performance by the principal regulating body. But the testimony of the major players, upon which so much of the telling relies, was remarkably convoluted, self-serving, evasive, and even deceptive. Indeed, the oral testimony of Jack Noonan, Claude White, Albert McLean, and John Smith often bordered on the surrealistic. To glean meaning from much of it was a formidable task. What is clear is that the department did not discharge its duties with competence or diligence, and thereby failed to carry out its mandated responsibilities to the workers at Westray and to the people of Nova Scotia.

Throughout this Report, I have attempted to provide the reader with as specific references as possible, at the risk of the narrative being lost in a sea of footnotes. Such an approach in this chapter on the Department of Labour threatened a virtual tidal wave of citations in trying to make some sense of much of the testimony. So, I have chosen to deal with precisely that – the *sense* of the evidence. The assertions in this chapter may readily be corroborated by reference to the pertinent transcripts. Many of those assertions are supported by relevant quotations in the body of the text or in footnotes. Documentary evidence is cited directly, as elsewhere in this Report.

¹ See Chapter 11, Department of Natural Resources.

² In this chapter, we refer to the department simply as Labour. Within the department, much of our attention is on the inspectorate, which includes the director of mine safety and his various inspectors, or safety officers.

Regulating Mine Safety

There are two general approaches to regulating safety in coal mining. The United States uses trained technicians to administer a detailed and comprehensive regulatory regime, with professional mining engineers and other specialists as back-up. Underground coal mining expert Don Mitchell described the extensive training technicians receive in the U.S. system:

Every inspector who is part of the Mine Safety and Health Administration must . . . before they start inspecting, attend three months of education and training at the [National Mine Health and Safety] Academy.

Every year this is followed up by, I believe, six weeks of training in various specialties as we develop specialists among these inspectors. This continues, at the minimum, this is not the max, this is the minimum for each inspector for as long as he remains an inspector.³

The second approach to regulating mine safety is to employ highly qualified professionals who exercise an informed discretion in enforcing regulations. In the United Kingdom, coal mine inspectors must be mine managers and mining engineers, trained in inspection. The British regime requires the active involvement of the inspectors in many planning or operational decisions.

Most underground mine inspectors in Canada are qualified mining engineers with training along the lines of the UK regime.⁴ Both the U.S. and the UK schemes require technical competence, mining experience, and training in the inspection process. In either approach, inspectors must be capable and prepared to enforce their governing regulations fairly and assertively.⁵

The regulatory scheme and the inspectorate under which Westray operated offered neither the detail of the U.S. *Code of Federal Regulations* nor the technical expertise and experience found in the United Kingdom. This fact may have contributed to the attitude of disrespect towards the inspectorate shown by Westray management as alluded to in the comments of Ray Savidge, describing an incident he witnessed:

[O]bviously the two company men were arguing with the mines inspector what they were – what they wanted to do and he must have been raising some objection. And they were arguing aggressively that this is what they wanted to do, which, to me, I thought well, it's wrong. I felt sorry for Mr. McLean because – but at the same time, there's something radically wrong there. Do you know what I mean, because you couldn't – a mine manager doesn't become aggressive in public with a mines inspector. I mean, you can't do that. The mines inspector is the authority in a real coal mining situation. I remember – you see, I remember these situations and they're kind of burned in there, you know, like, I forgot lots, but this situation. . . .

³ Hearing transcript, vol. 16, pp. 2974–75. Mitchell was involved in writing many of the regulations that apply to underground coal mines in the United States.

⁴ Those employed by Labour Canada, British Columbia, and Ontario, for example.

⁵ Much of my knowledge and many of my impressions about mine inspection come from visits to mines and discussions with people in regulatory positions in both the United States and Canada. For details, see the section on mine visits in Chapter 16, *The Inquiry*.

*No mines inspector that I've ever known in the real world would have tolerated that. You see, this is – these are things which you remember which are not normal, eh?*⁶

The first step towards an appreciation of Labour's performance is to review the applicable statutory duties and responsibilities of the department, the mandate as perceived by department staff and officials, the job descriptions, and the qualifications and background of the individuals charged with fulfilling that mandate.

Legislative Regime

In 1986, the staff and functions of the Mine Safety Division of the Department of Mines and Energy were transferred to the newly created Occupational Health and Safety Division of the Department of Labour.⁷ The new division was charged with the administration of the *Occupational Health and Safety Act* along with the statutory duties and pre-existing functions of the units transferred to it. Through oversight, statutory responsibility for portions of the *Coal Mines Regulation Act* was not transferred with the mine inspection unit, thereby causing a gap in the administration of the act.

Coal mine safety was to be governed by the *Coal Mines Regulation Act*, the *Occupational Health and Safety Act*, and the *Mineral Resources Act*.⁸ The *Coal Mines Regulation Act* addresses underground coal mining safety. The act was developed in the last century and updated in the 1950s, before many modern advances in mining technology took place. It provides standards for dealing with coal mining hazards – coal dust and explosive and noxious gases.

Section 48(2) of the *Occupational Health and Safety Act* brought the provisions of the *Coal Mines Regulation Act* into the new regime. That section provided that every reference to the Mine Safety Division of the Department of Mines and Energy should be construed as a reference to the Occupational Health and Safety Division of the Department of Labour. Section 43 of the *Occupational Health and Safety Act* provided that the health and safety of employees be deemed to be endangered by any violation of any provision of the *Coal Mines Regulation Act*. The inspectorate retained its discretionary range of responses to violations, with power to enforce compliance.

According to the *Mineral Resources Act*, the minister of mines and energy (natural resources after 1991) retained the responsibility to review mining operations not conducted in accordance with approved plans. Senior staff in Natural Resources said they thought responsibility for ensuring operators mined in compliance with approved plans was part of

⁶ Hearing transcript, vol. 22, pp. 4364–65. Emphasis added.

⁷ The history of the departmental responsibilities with respect to mines is discussed in Chapter 11, Department of Natural Resources. Note that, prior to September 1991, the Department of Natural Resources was known as the Department of Mines and Energy.

⁸ RSNS 1989, c.73; RSNS 1989, c. 320; and RSNS 1989, c. 286, respectively.

the inspectorate's role. They felt that this function had been transferred to Labour with the mine inspection unit. This gap in statutory responsibilities has been addressed in the previous chapter. From Labour's perspective, the gap confused the issue of regulatory responsibility for evaluation of mine plans and operational safety. Labour witnesses said that assessment of the operational safety of proposed mining methods was an engineering function retained by Natural Resources. This confusion meant that neither department performed those functions to ensure the mine was developed safely according to a plan and mining method approved for safety.

No other provincial department or agency was involved in monitoring Westray for standards of occupational safety. The lender, the Bank of Nova Scotia (BNS), retained Associated Mining Consultants Ltd (AMCL) to monitor the project's development expenditures and production rates.⁹ AMCL required that the company regularly affirm that it had not received any notification of non-compliance with the law. According to AMCL's Alan Craven, AMCL relied on the Department of Labour to check for safety violations but had no direct contact with Labour about the company's compliance.¹⁰ The province was required by the financing agreement to notify the bank of any compliance issue that might jeopardize the continued operation of the project. BNS liaison Brian West told the Inquiry that the principal obligation to inform the lender lay with the operator of the mine.¹¹

Regulation of the occupational health and safety of Westray employees was entrusted to Labour. Of Labour's four occupational health and safety divisions, the mine safety division (generally referred to in this Report as the inspectorate) had the most regular contact with Westray. The mine inspectorate was responsible for monitoring compliance with legislation governing operational safety at Westray. The range of this mandate had not been clearly defined.

Organization of the Department of Labour

The Department of Labour in 1991 was organized in seven divisions, the largest of which, the Occupational Health and Safety Division, included mine inspection. The executive director of the Occupational Health and Safety Division, Jack Noonan, reported to the deputy minister, Hugh Macdonald. Reporting to Noonan was Claude White, director of mine safety and head of mine inspection.

Noonan joined the Department of Labour in the mid-1980s as executive director of health and safety. He is a professional engineer with a degree in chemical engineering. He came from an industrial safety background in Ontario and served as superintendent of safety for INCO for several years. As executive director of health and safety for the

⁹ AMCL had prepared a geological report for Placer Development's 1987 feasibility study on the Pictou coalfield.

¹⁰ Hearing transcript, vol. 49, p. 10683.

¹¹ Hearing transcript, vol. 49, p. 10778.

department, Noonan was responsible for the administration of the *Occupational Health and Safety Act* and the safety aspects of the *Coal Mines Regulation Act*. He acknowledged this responsibility at the hearing. Noonan had no underground coal mining qualifications or experience.¹² He said he had never read the *Coal Mines Regulation Act*.¹³ This was a shocking revelation, but it merely set the stage for Noonan's disingenuous interpretation of his role and that of his division. I would have thought that any competent and conscientious administrator would have a good working knowledge of all regulations, statutes, or rules coming within the ambit of his or her responsibility. Noonan's evidence merely confirmed that he did not.

The position description for executive director stated that this position was accountable for:

planning, developing, co-ordinating and the monitoring for compliance of policies, programs and existing legislation and regulations pertaining to the occupational health and safety of employees and self-employed persons in the Province of Nova Scotia. In addition, it is accountable for development, recommendation and implementation of new regulations, guidelines, standards, policies and programs relating to the *Occupational Health and Safety Act* and other specific Public Safety Acts.

...

It is the responsibility of the Executive Director to exercise administrative and operational control on all fiscal, personnel and technical aspects of the Division.

...

The Executive Director controls all aspects of the Division and is required to consult with the Deputy Minister only on major policy or personnel matters.¹⁴

White indicated that Noonan gave little support and guidance for the mine inspectorate, and that any flow of information to Noonan's superiors was blocked. White added: "We operated pretty well on our own."¹⁵ Noonan's concept of the responsibilities of the inspectorate, as we shall see, was a major deterrent to effective enforcement of the safety regulations relating to underground coal mining.

Noonan acknowledged in testimony that he had been alcohol dependent while serving as executive director.¹⁶ His immediate superior, deputy minister Hugh Macdonald, was aware of this problem. Macdonald's concern was "to the extent that I felt a problem was developing . . . for which he needed counselling."¹⁷ It is unclear to what extent Noonan's alcohol dependency may have affected his ability to administer the inspectorate.

¹² Hearing transcript, vol. 69, pp. 15058–60, 15109.

¹³ Hearing transcript, vol. 69, p. 15193.

¹⁴ Exhibit 141.05.001–003.

¹⁵ Exhibit 126.1, p. 53.

¹⁶ Hearing transcript, vol. 69, p. 15154.

¹⁷ Hearing transcript, vol. 69, p. 15258.

Deputy minister Macdonald took no direct part in the routine operation of the mine inspection unit. As chief administrative officer of the department, he was responsible for seeing that the department applied the acts and regulations in its charge. He relied on seven or eight directors to report on the matters in their respective divisions, and at times asked them for information on anything he felt would interest or concern the minister. He was not familiar with the *Coal Mines Regulation Act* and considered both Noonan and White responsible for guiding and directing the mine inspectors in relation to the relevant legislation and policy.¹⁸

The issue of ministerial responsibility was raised at different times in this Inquiry and it is addressed in Chapter 13, The Politicians and Ministerial Responsibility. The appropriate role for a deputy minister is touched on in a number of places, most notably the section dealing with John Mullally's performance as deputy minister of natural resources.¹⁹ It seems evident that any deputy minister has a duty and responsibility to become familiar with the operations of his or her department and with the legislation and regulations administered by that department. There was also a duty on the deputy ministers of labour and natural resources to ensure that there were no gaps in the administration of their responsibilities as set out in the respective legislation.

Macdonald assumed that Noonan's job performance was acceptable and that Noonan and White were providing appropriate direction to the coal mine inspectorate. In the final analysis, this confidence was misplaced. Harry Rogers, deputy minister of Industry Canada, spoke to the necessity for senior administrators to gain sufficient understanding of their department's work to test the capabilities of staff to perform that work. Then they fill any gaps and "change the people" as necessary. "And that would be a normal management process of testing and validating whatever materials are put to you for decision or on which you're expected to give direction."²⁰ Senior administrators within the Department of Labour did not execute this essential function.

Mine rescue trainer Fred Doucette tried to explain these deficiencies in the department by suggesting that senior administrators were unfamiliar with underground coal mining:

I think basically people in the Department of Labour could not accept a coal mine for what it is, as a workplace. A coal mine is a dirty, dusty, damp, and dangerous work environment at the best of times.

I think that the Department of Labour tried to lump that workplace in with places like a fish plant or . . . Canadian Tire store or whatever. . . . and I'm still not sure today that they recognize a coal mine for what it is.²¹

This explanation does not factor in the qualifications and experience of Claude White, a professional mining engineer with a lengthy employment

¹⁸ Hearing transcript, vol. 69, pp. 15219–23, 15233.

¹⁹ See the section on the "feather plan" in Chapter 11, Department of Natural Resources.

²⁰ Hearing transcript, vol. 62, pp. 13552–53.

²¹ Hearing transcript, vol. 62, p. 13618.

record including time with Labour Canada as a safety engineer at Devco No. 26 colliery.

Mine Inspection Division

The mine inspectorate in 1991 included a technical staff of six, John Smith, Albert McLean, Fred Doucette, Dave MacLean, Ralph Henwood, and Jude Kelly, who were located in Glace Bay, Springhill, Stellarton, and Halifax. Smith, an electrical-mechanical inspection officer stationed at Stellarton, and Albert McLean and Fred Doucette, safety officers classified as inspector/instructor mine rescue, were the staff assigned to inspection duties at Westray.²² Smith reported to White, the chief inspector; Doucette and McLean reported to Colin MacDonald, supervisor of mines inspection in Glace Bay. After MacDonald retired on 1 December 1991, they reported to White. Dave MacLean, Henwood, and Kelly had no significant work assignments at Westray prior to the explosion.

Claude White, director of mine safety and head of the mine inspectorate, was the most senior official in the Department of Labour with any coal mining training or experience. He graduated from the Technical University of Nova Scotia in 1970 with a degree in mining engineering. He worked about 12 years in open-pit coal and base metal mines. He was a district mine safety engineer for Devco in Cape Breton from 1983 to 1988, providing technical support and advice to mine inspectors in No. 26 colliery. With the mine inspection unit cut off from the engineering and technical staff in Natural Resources, it fell on White to provide professional engineering support for the inspectors along with his administrative duties.²³

John Smith joined the National Coal Board in the United Kingdom as a trainee coal miner, and progressed from apprentice electrician through class I electrician to a higher national certificate in electrical engineering. Aside from a mandatory 14-week underground training program for all new underground workers, and his background in mine-related electrical matters, Smith had no training or certification in coal mining.²⁴ He was appointed an electrical inspector with the Nova Scotia Department of Mines in 1963 and assumed responsibility for mechanical inspection in 1973 after several provincial inspectors joined the federal inspectorate in Cape Breton.²⁵ Although Smith found it relatively easy to add mechanical inspection to his duties, since electrical and mechanical matters so frequently overlap, he described how the shrinking of the department affected mine inspection: “[T]he problem with these small departments . . . and they get smaller, is that you’ve got to know a little bit about everything, but not maybe too much about anything in particular.”²⁶

²² Exhibit 139.12.001.

²³ Hearing transcript, vol. 62, pp. 13678–94.

²⁴ Hearing transcript, vol. 58, pp. 12626–30.

²⁵ Hearing transcript, vol. 58, pp. 12633–39.

²⁶ Hearing transcript, vol. 58, pp. 12641–43.

Albert McLean worked as a labourer in Cape Breton mines for 12 years, where he obtained miner and mine examiner certification. He became a longwall mechanic in 1972, moved up to supervisor of mechanics in 1974, and became a qualified mine rescue team captain. He went to night school and qualified for certification to the mine manager level, but was never employed in the coal mining industry above the level of mechanical supervisor. His mining experience gave him little exposure to modern mechanized room-and-pillar mining.²⁷ McLean joined the provincial mine inspectorate in 1978. He received no training in inspection. He was not accompanied by an experienced inspector on his first tour of inspection. He knew of the inspection process only from observations of inspectors in mines where he had worked.²⁸

Fred Doucette left school in Grade 12 and started in a coal mine as a labourer. He worked room-and-pillar operations at the Drummond coal mine in Pictou County from 1949 to 1977 and rose to overman, a second-level supervisory position. He attended night school for four years and was certified to the mine manager level in 1965. He worked as a mine manager for two weeks in 1970.²⁹ Doucette joined the provincial inspectorate in 1977. He was responsible for the organization and coordination of mine rescue programs until his retirement in 1994. He maintained mine rescue equipment, lectured on mine rescue, instructed rescue crews, and tested candidates for certification in mine rescue, including those from the federally run mines.³⁰ Doucette never worked as a general coal mine inspector. He and McLean held the same job title and certification, and considered themselves equally qualified. When the mine rescue staff was reduced, Doucette retained his position because of seniority and his health problems, which were aggravated by dusty underground conditions.³¹

Colin MacDonald, the supervisor of mines inspection in Glace Bay, worked 21 years in the Cape Breton coalfield and was a certified mine manager when he was hired for the mine rescue position later held by Doucette. In 1978, he was promoted supervisor of mines inspection, and he held that position until his retirement on 1 December 1991. His last underground tour of Westray was on 3 September 1991, when development had reached somewhere between No. 9 and No. 10 Cross-cuts.³²

MacDonald's 1981 Mines and Energy job description made him accountable for the direct supervision of mine inspection and mine rescue programs, and for maintaining a well-trained inspectorate through educational programs.³³ At the request of the executive director of Occupational Health and Safety, MacDonald spent the last few months

²⁷ Hearing transcript, vol. 54, pp. 11847–59.

²⁸ Hearing transcript, vol. 55, pp. 11889–92.

²⁹ Hearing transcript, vol. 60, pp. 13169–73.

³⁰ Hearing transcript, vol. 60, pp. 13173–75.

³¹ Hearing transcript, vol. 60, pp. 13179–84.

³² Pre-hearing interview transcript, 22 January 1996, pp. 2–5, 30.

³³ Inquiry file, DOL Box4A 33.

before his retirement rewriting coal mining legislation. His position was not filled after his retirement.

Assignments at Westray

In a memo to the mine safety officers dated 5 April 1989, White named John Smith as “responsible for coordinating and monitoring new mining activity, mine plan control, development of new mining regulations and monitoring the activity of the new Pictou Coal mine.”³⁴ Smith’s assigned responsibility for mine plans at the Stellarton office apparently referred to an archive of final plans of closed mines rather than a library of plans for mines in current operation.³⁵ Albert McLean, based at Glace Bay, was responsible for routine inspections in an area that included the Westray site in Pictou County, coordinating inspection activities with Smith, and assisting Smith with the Pictou Coal project.

The inspectors understood that Smith would concentrate on electrical-mechanical matters and McLean on general coal mine inspection. Smith, in Stellarton, was conveniently located for inspection during tunnel driveage, when much of the work involved drafting conditions for the use of equipment not covered by the *Coal Mines Regulation Act*. McLean carried the role of “general inspector” as the project got into coal.

Job descriptions had been developed and approved before the mine inspection unit was transferred to Labour in 1986. New job descriptions were not adopted, though new job titles were. According to their job descriptions, the “safety officers” were to perform the same duties that had been required for their Department of Mines and Energy jobs. It is clear from the evidence that there was some confusion, or misunderstanding, respecting the duties and responsibilities of the inspectors, and indeed, respecting the department as a whole. This problem was exacerbated by the lack of communication among the inspectors. It was compounded by the lack of communication between the Department of Labour and the Department of Natural Resources and is evident in the following discussion respecting the duties of the several levels of the inspectorate.

Duties of the Director of Mine Safety

Claude White was hired as the provincial director of mine safety in July 1988, following the transfer of the mine inspection unit to Labour and following the departure of the former chief inspector of mines, Walter Fell, who had transferred with the unit. White had the same duties and responsibilities as Fell, although White was not appointed chief inspector under either the *Coal Mines Regulation Act* or the *Mineral Resources Act*. White understood his job to include whatever remained of the responsibilities of the chief inspector under the *Coal Mines Regulation Act*, given the new *Occupational Health and Safety Act* regime.³⁶

³⁴ Exhibit 139.01.06.

³⁵ Hearing transcript, vol. 59, p. 13041.

³⁶ Hearing transcript, vol. 62, pp. 13693–97.

According to the 1981 job description, White was accountable to ensure that Nova Scotian mines and quarries were “operated in accordance with modern worker health and safety principles through frequent analysis of workplace hazards and corrective measures, establishment of appropriate regulations and regular, thorough mine inspection programs.”³⁷

The same job description included responsibility for pre-development health and safety review of plans for new operations and approval of new facilities, equipment, and procedures. The director was to work closely with the engineering group in Mines and Energy to resolve operating and inspection problems. He was to ensure the quality of mine inspection through training and supervision.

Duties of the Electrical-Mechanical Inspector

The approved position description for Smith’s job as senior electrical-mechanical inspector made him responsible, “under the general supervision of the Chief Inspector of Mines . . . for the development and implementation of mine electrical-mechanical inspection programs as required by provincial legislation . . . to ensure safe installation and operation of equipment, to prevent injury to personnel, damage to plant, and loss of production.” It required the inspector:

- to conduct personal inspections of mines to ensure that safe conditions were maintained
- to monitor new mining projects for regulatory compliance
- to monitor new equipment and techniques
- to report on electrical/mechanical safety problems and violations, and to recommend corrective action.³⁸

Smith understood his job at Westray was “trying to make sure that the equipment is kept in reasonable condition.” He described his relationship with the “coal inspector” as being “like a team thing”; Smith was prepared to keep an eye out for general safety matters and pass along anything of concern.³⁹ He and White jointly signed approvals for Westray’s underground equipment.

In late 1991, White asked Smith to write to Westray mine manager Gerald Phillips about producing a stonedusting plan. Smith also called Phillips about setting a firm deadline for the plan. After that, he had no more involvement in the matter.⁴⁰ Smith said that he, McLean, and White may each have assumed that one of the others was following up. Work activity reports were not routinely circulated among them.⁴¹ There was little direct contact between Smith and McLean, the latter being based in Glace Bay. Smith, who had never worked directly with McLean before Westray, assumed that McLean was competent.

³⁷ Inquiry file, DOL box 4A 33.

³⁸ Exhibit 139.08.001–002.

³⁹ Hearing transcript, vol. 58, pp. 12646–50.

⁴⁰ Hearing transcript, vol. 58, pp. 12769–71.

⁴¹ Hearing transcript, vol. 58, pp. 12697–98.

Smith thought that McLean was responsible for ensuring compliance with such provisions of the *Coal Mines Regulation Act* as:

- visiting monthly every underground roadway and section and approving roadways for travel
- reviewing ventilation plans for airflow, examining the condition of stoppings and the use of doors in stoppings, checking quality of intake air, assessing the operation and location of auxiliary fans
- checking shift reports, especially for reference to stonedusting
- enforcing the prohibition against shifts longer than 8 hours in a 24-hour period
- checking the presence of a barometer, thermometer, and water gauge in the mine.⁴²

Smith did not carry a methanometer in the mine and relied on company officials to check the air during his trips underground.⁴³

Duties of the Mine Inspector

McLean's job description stated that he was responsible for inspection of the mine to ensure compliance with the *Coal Mines Regulation Act* and the *Mineral Resources Act*. He was to meet with mine officials and recommend corrections of problem areas, and to report findings to his supervisor. His duties included:

- carrying out regular safety inspections to identify actual and potential hazards
- following modern procedures of mine inspection, such as testing for noxious gases, carrying out stonedust surveys to prevent accumulations of coal dust, and conducting noise and respirable dust surveys
- assisting the board of examiners in training mine examiners and supervisors, in issuing coal miners' certificates of competency, and in conducting and overseeing mining examinations
- participating in seminars and meetings to promote workplace safety
- assisting mining engineers as required; mining engineers were to be consulted about problems relating to mine ventilation, roof control, and resource management.

The job description specified that the mine inspector "[m]ust cause an operation to be stopped if it is unsafe or if it does not comply with the provisions of the regulation acts. Refers all decisions that are not routine to higher authorities."⁴⁴

McLean said that he was never told the limits of his responsibilities at Westray. He knew he had powers under the *Coal Mines Regulation Act* to examine the operation, to have unsafe practices corrected, and to stop work if necessary. He was not clear about the circumstances that might

⁴² Hearing transcript, vol. 59, p. 12961; vol. 60, pp. 13091–102.

⁴³ Hearing transcript, vol. 59, pp. 12941–42, 12964–66; vol. 60, p. 13070.

⁴⁴ Exhibit 139.03.01–04. Emphasis added.

require the exercise of his statutory powers. He said he was to look for unsafe work practices and check for gases and evidence of stonedusting. He was to tell management when more dusting was needed, and to have management send dust samples for laboratory analysis of combustibility if he didn't think the level of stonedusting was sufficient. Similarly, he was to require corrective action if he detected unacceptable levels of gases.⁴⁵

McLean said that he had no responsibility to approve ventilation plans or auxiliary ventilation, to know ventilation routes, or to review ventilation surveys. He did not know the conditions and exemptions for use of equipment, and he did not know of the manager's rules or the codes of practice for the mine. He did not consider himself competent, nor did he believe it his duty, to evaluate stoppings beyond obvious failures, to review mine plans or mining methods, or to monitor for compliance with approved plans.⁴⁶

McLean said that complex matters were the responsibility of the engineers. He thought that his seniors in the department were not particularly interested in the input of inspectors on matters requiring expert professional opinion.⁴⁷ He assumed that the presence of "experts" working in the mine meant that they had tacitly approved of or were responsible for any questionable practice in the mine.⁴⁸ McLean said "them men were working in a safe environment when I was underground at that mine on those days."⁴⁹

White surmised that McLean had merely expressed himself badly if he had left an impression that he felt responsible for mine safety only when he was actually in the mine himself: "But certainly, we are concerned about the safety of that mine 24 hours a day, 365 days a year." He suggested that McLean meant to express that the inspectors could assume an operation was safe, in the absence of any indication to the contrary.⁵⁰ This was not consistent with McLean's testimony.

White said that detection and resolution of complex issues were the responsibility of the company and its engineers, with government engineers ensuring that problems were being addressed. McLean was to look for the more obvious and rudimentary indicators of safety concerns. McLean did not accept the list of tasks that White thought was the responsibility of a mine inspector.

White said it did not require much technical expertise for the mine inspector to administer the *Coal Mines Regulation Act*, since company engineers would assess technical matters, such as the adequacy of

⁴⁵ Hearing transcript, vol. 55, pp. 11913–35.

⁴⁶ Hearing transcript, vol. 55, pp. 11916–25, 11969–73, 12023–24.

⁴⁷ Hearing transcript, vol. 55, p. 11950.

⁴⁸ Hearing transcript, vol. 56, p. 12344. McLean admitted to overlooking the lack of a barometer at Westray, but seemed intent on having others share the blame: "But overlooked by experts that were down in that mine didn't see a barometer."

⁴⁹ Hearing transcript, vol. 55, p. 11915.

⁵⁰ Hearing transcript, vol. 63, pp. 13740–41.

stoppings, and McLean was only expected to check for anything obviously unsafe.⁵¹ “Our responsibility,” he said, “was to monitor those [mine work]places and to, if we saw deficiencies . . . have them corrected.”⁵² White expected McLean to determine periodically that ventilation plans existed and to check ventilation by testing for gases and sufficiency of oxygen. McLean was to ensure that auxiliary ventilation was in accordance with regulations. According to White, McLean should have been able to detect such problems as series ventilation. It was the company’s responsibility to deal with the more complex aspects of ventilation. White found it acceptable for McLean not to know about such concerns as methane layering or how to check for the presence of methane layers.⁵³

White concluded that the mine ventilation at Westray provided too great a velocity for layering. There appears to be little basis for this conclusion, which, in fact, was wrong. He expected the underground environmental monitoring system to detect any problems, in spite of the fact his department had never checked on the reliability of the system.⁵⁴

Finding

The training and experience of the inspectors responsible for Westray were inadequate. Their performance was also diminished by a lack of guidance and supervision. Claude White, the director of mine safety, did not do his job of monitoring the system and ensuring that any difficulties were corrected.

Duties of the Mine Rescue Inspector

Doucette worked on mine rescue training and inspection throughout the province. When Canadian Mine Development (CMD) was driving the tunnels at Westray, Doucette trained its mine rescue teams, as required under the *Coal Mines Regulation Act*. Doucette disagreed with his supervisor’s instruction to put on a “crash course” of 48–50 hours of training over two weeks rather than over a year. Despite Doucette’s disagreement, it was the method followed, as it had been during tunnel driveage for Devco’s Donkin mine in Cape Breton.⁵⁵

When Westray took over from CMD, mine rescue training followed that of the federally run coal mines in Cape Breton, rather than the program used at the independent mines in the province. Westray provided its own mine rescue training program. Doucette tested the trainees for certification, checked rescue equipment, and monitored the program

⁵¹ Hearing transcript, vol. 63, p. 13975.

⁵² Hearing transcript, vol. 62, pp. 13695–96.

⁵³ Hearing transcript, vol. 63, pp. 13976–78; vol. 64, p. 14066.

⁵⁴ Hearing transcript, vol. 63, pp. 13980–81. **Comment** As we have seen in Chapter 5, Working Underground at Westray, the installed system was completely unreliable and had never operated properly.

⁵⁵ Hearing transcript, vol. 60, pp. 13202–03.

generally. This was consistent with Labour's emphasis on company responsibility for safety.⁵⁶

Smith suggested that Westray wanted its own program to minimize contact between miners and the inspectorate, but Doucette dismissed this as "far-fetched."⁵⁷ Doucette cited Noonan's version of the internal responsibility system (IRS) as the reason Westray was the first mine in provincial jurisdiction to do its own mine rescue training.⁵⁸ He found the company generally responsive to his requirements, though Phillips did balk at spending \$25,000 to complete the set of Draeger gear at the mine site. Doucette loaned the gear to the company; he told the Inquiry that Phillips "wasn't the kind of a person you're going to confront and get away with very easily."⁵⁹

After the explosion, Doucette was assigned to Labour's own investigation team, with mine inspector Ralph Henwood and investigator Harry Murphy. During testimony, there was some confusion concerning methane readings attributed to McLean in the final report made by this investigating team; these readings were supposedly taken during McLean's 29 April site visit at Westray, but may have been confused with earlier readings. Doucette stated that he had not read that final report before its submission to the department, though he had signed it.⁶⁰

Perception of Mandate

The inspectors themselves were confused about their roles in Noonan's occupational health and safety system. They saw a conflict between those roles and the duties of inspectors under the *Coal Mines Regulation Act*.

It should be noted that Labour also developed policies of general application, which affected how the mine inspectorate performed. Both Smith and Doucette recalled that companies were to be encouraged to comply voluntarily with regulations. It was strongly suggested that there be three warnings before an order was issued. Noonan said that this policy did not apply to situations of imminent danger, and the inspectors were mistaken if they thought the policy was mandatory. The proposition of "three strikes and you're out" applied "only if the circumstances were appropriate."⁶¹ Stronger action was to be reserved for persistent and flagrant violations.⁶²

⁵⁶ Hearing transcript, vol. 60, pp. 13188–89.

⁵⁷ Doucette (Hearing transcript, vol. 60, pp. 13193–94). Smith's opinion is at Exhibit 128.1, p. 46. When viewed in the context of the overall relationship between the inspectorate and Westray management, notably Gerald Phillips and Roger Parry, Smith's suggestion might not be so far-fetched.

⁵⁸ The concept of "internal responsibility" and Noonan's interpretation are explored in the following section of this chapter (Internal Responsibility System).

⁵⁹ Hearing transcript, vol. 60, pp. 13186–88.

⁶⁰ Hearing transcript, vol. 60, pp. 13298–300. **Comment** I do not recall Doucette offering any explanation for this oversight, which put into question the accuracy and thoroughness of the report and the commitment of the authors.

⁶¹ Hearing transcript, vol. 69, pp. 15185–87.

⁶² Hearing transcript, vol. 69, p. 15173.

Noonan expressed surprise that the inspectors were confused about their roles. He said that the inspectors had all been trained in the interpretation of the *Occupational Health and Safety Act* and in his own interpretation of the internal responsibility system.⁶³ Although Noonan had never read the *Coal Mines Regulation Act*, he assumed that the duties and responsibilities of the inspectorate remained as they had been under the Mines and Energy regime, except that the inspectors were to enforce only the occupational health and safety portions of the act. According to Noonan, it was the same job description but adapted to the internal responsibility system.⁶⁴

Noonan said that effective enforcement of mine safety legislation such as the *Coal Mines Regulation Act* need not conflict with a modern occupational health and safety regime based on the internal responsibility system. That statement makes sense only as long as Noonan's own passive and non-interventionist interpretation of the IRS does not apply. We know that the inspectorate does play an effective role in other jurisdictions using the IRS approach outlined in the following section of this chapter.

Claude White said that the *Occupational Health and Safety Act* and Noonan's version of internal responsibility made the company and workers responsible for safety at Westray.⁶⁵ He recognized that the *Coal Mines Regulation Act* requires active involvement of the inspectorate in the planning and operation of a coal mine. The inspectorate approves such matters as the mining method, ventilation, roadways, equipment, and use of electricity in the mine.⁶⁶ He referred to the inspectors' duties and responsibilities under the *Coal Mines Regulation Act* as "ongoing technical detailed monitoring at the mine site." He felt this role conflicted with what was expected of the inspectorate under the occupational health and safety regime, the latter being limited to auditing the company's attempts to fulfil its responsibility for health and safety. In trying to reconcile the incompatible aspects of the two acts, White said, the inspectorate had only done "a little bit of both."⁶⁷ He suggested that these efforts to implement contradictory approaches had failed – by perpetuating a reliance on an external agency that was no longer accepting any responsibility for ensuring mine safety.⁶⁸ White's evidence gives the reader a glimpse of the convoluted thinking and confusion that seemed to paralyse the inspectorate and render it ineffectual in discharging its legislated responsibilities.

White was inconsistent in his approach to the provisions of the *Coal Mines Regulation Act*. He declined to enforce some regulations at Westray even though he had no such discretion. Many of the outdated and obsolete

⁶³ Hearing transcript, vol. 69, pp. 15122–23.

⁶⁴ Hearing transcript, vol. 69, pp. 15120–21.

⁶⁵ Hearing transcript, vol. 63, pp. 13958–59.

⁶⁶ Exhibit 141.01.054.

⁶⁷ Hearing transcript, vol. 62, p. 13713.

⁶⁸ Hearing transcript, vol. 62, pp. 13728–33.

provisions of the act had to be ignored, since they had no application in a modern coal mine such as Westray. Some electrical specifications were unworkable, as were some equipment requirements.⁶⁹ These anomalies led John Smith to comment that compliance with all the provisions would have required the operator to “rob a museum.”⁷⁰

In other instances, White extended his authority to give approvals in areas not contemplated by the act. These decisions were based on accepting precedents from other jurisdictions but without ensuring appropriate controls. Equipment and materials specialist John Bossert warned: “There’s a danger in . . . copying a procedure used in another country unless you copy the entire procedure. In other words, the enforcement must be very strict.”⁷¹ He spoke in reference to the approval for use underground at Westray of non-flameproof diesel utility vehicles, which are permitted in the United States. White relied on the company to enforce restrictions on the use of the tractors, whereas the U.S. regime involves comprehensive monitoring by the Mine Safety and Health Administration (MSHA).

White’s failure to enforce the *Coal Mines Regulation Act* prohibition against shifts longer than 8 hours appeared based on personal preference and the tentative conclusions of a single North American study.⁷² White recognized that he had no authority to choose not to enforce the act. He described his approach as the exercise of discretion in deferring decisions, pending resolution of more pressing concerns.⁷³

White said that neither he nor his inspectors had any responsibility to check mine plans, though they might examine plans at the mine site during inspections. Owners and their engineers were responsible for the safety aspects of plans, and Natural Resources monitored plans from the resource management perspective. White considered it to be immaterial that inspectors had not known when they were in areas of the mine not developed in compliance with an approved mine plan. In his opinion, that omission had no impact on worker health and safety.⁷⁴ If director of mining engineering Pat Phelan and the engineers in the Department of Natural Resources assumed that the inspectors were responsible for ensuring compliance with an approved mine plan, White said, they were mistaken. White declined the offer of copies of approved mine plans from

⁶⁹ For example, the act does not allow for the operation of diesel-powered equipment underground except for diesel locomotives on rail.

⁷⁰ Hearing transcript, vol. 58, p. 12685.

⁷¹ Hearing transcript, vol. 12, p. 2149.

⁷² Hearing transcript, vol. 64, pp. 14176–78. Other jurisdictions may be moving to shorter underground work periods rather than longer. Malcolm McPherson told the Inquiry that “[s]ome mines in the world have now gone to four shifts working six hours, Mr. Commissioner. 12 hours is excessive” (vol. 9, p. 1705).

⁷³ Hearing transcript, vol. 64, pp. 14182–83. This approach to the enforcement of the law must have sent mixed signals to Westray management. It surely would have encouraged and increased the already clear disdain that Westray had for any sort of regulatory constraints.

⁷⁴ Hearing transcript, vol. 62, pp. 13736–37; vol. 63, pp. 13826–33.

the Department of Natural Resources, an act he felt should have made Phelan aware that inspectors were not monitoring plan compliance.⁷⁵

Finding

The inspectorate did not routinely review Westray's mine plans. A review of approved plans might have revealed potential safety problems that were not obvious during inspections. Competent review by regulators might have moved the company to consider changes more carefully.

White said there was no reason for mine inspectors to be concerned with deviations from approved mine plans or with changes in mining method, in the absence of “indicators” that such would impair safety.⁷⁶ White used the same terminology in describing the inspectorate’s approach to ventilation and other regulatory requirements. The inspectorate was to check periodically to ensure that these were all in place, relying on the absence of any “indicators” to the contrary.⁷⁷ When any indicators were detected, the inspectorate referred the matter back to the company for corrective action. Smith provides us with a good example of this approach on the issue of dimming cap lamps (discussed in Chapter 5, Working Underground at Westray). He said that his not having heard further about the concern meant that it was resolved. He commented, “Well, I don’t have any evidence that nothing was done. I must have been satisfied with whatever explanation I was given.”⁷⁸

These attitudes respecting the responsibilities of the inspectorate are inconsistent with my understanding of the operation of the safety inspectorate in British Columbia and Ontario, and, indeed, in many jurisdictions in the United States. In those areas the inspectorate is aggressive in requiring compliance. At the risk of sounding flippant, one might conclude that Claude White’s inspectorate could have just as well “closed shop” and gone elsewhere – its absence may have gone unnoticed.

It seems that it was Noonan’s version of the IRS that permeated the inspectorate.

⁷⁵ “[W]e did not consider that our role” (Hearing transcript, vol. 63, pp. 13990–91). John Laffin, former deputy minister of Natural Resources, found it very strange that White would not want the approved plans: “I don’t understand” (vol. 70, pp. 15499–500).

⁷⁶ Hearing transcript, vol. 63, pp. 13839–40. Expert witnesses agreed on the necessity of reviewing operations for compliance with approved mine plans. Miklos Salamon spoke to the Inquiry about the withdrawal from Southwest 1. He considered it to be “a significant departure from normal mining practice and apparently neither departments have taken note of it or done anything about it or tried to find out the basis on which this was planned or designed. So it’s not giving you the impression of very thorough competent regulation or enforcement” (vol. 14, p. 2435).

⁷⁷ Exhibit 126.1, pp. 19, 61.

⁷⁸ Hearing transcript, vol. 59, p. 12889.

Finding

Albert McLean was not competent to perform all the duties of a mining inspector or to enforce routinely the provisions of the *Coal Mines Regulation Act*. Even in those areas where he should have had competence, he failed to perform his duties with diligence or concern. His performance was unacceptable, and this fact ought to have been obvious to his supervisors. His supervisors ignored or glossed over his inadequacies and made no effort to supervise, train, or direct him, or to monitor his activities at Westray.

John Smith was qualified for his position as electrical-mechanical inspector. In those areas he seemed to perform with some competence. He did not perform his duties with the aggressiveness and vigour needed to offset the attitudes and laxity of Westray management.

Neither Smith nor McLean was given a clear indication of his duties and responsibilities. Both Smith and McLean followed the version of the internal responsibility system as determined by Jack Noonan and promoted by Claude White.

By and large, the performance of Smith and McLean as mine safety inspectors at Westray was inadequate and did little to convey to an aggressive and disdainful Westray management that safety was paramount and that non-compliance with safety rules and regulations would not be tolerated.

Finding

Jack Noonan erred in advocating his version of the internal responsibility system (IRS), and in claiming that inspectors could enforce the *Coal Mines Regulation Act* properly while following directives based on his version of the IRS.

Internal Responsibility System

It seems to me useful at this point to digress from the review of the inspectorate to discuss in some detail the concept of the internal responsibility system as it is understood in other jurisdictions and in Nova Scotia. My first encounter with the concept of “internal responsibility” in this Inquiry was in reading the Burkett and Ham reports.⁷⁹ The term was mentioned in Burkett, under the general heading of “direct responsibility,” in the context of fixing primary responsibility for safety with the top management of the operation, whether mining or any other. It seems almost axiomatic that the organization wishing to carry on a commercial enterprise must bear the primary responsibility of ensuring a safe working environment. This concept of internal responsibility did not have any particular significance at the Inquiry until the Department of Labour

⁷⁹ Joint Federal-Provincial Inquiry Commission into Safety in Mines and Mining Plants in Ontario, *Towards Safe Production*, 2 vols. (Toronto, 1981) (Chair Kevin M. Burkett) [Burkett Report]; Ontario, Royal Commission on the Health and Safety of Workers in Mines, *Report* (Toronto: Ministry of the Attorney General, 1976) (Commissioner James M. Ham) [Ham Report].

witnesses appeared before it. Their testimony gave the concept an interpretation that was impossible to reconcile with any notion of a prudent and safety-oriented regulatory regime.

Department of Labour and Internal Responsibility

Inquiry counsel endeavoured in some weeks of laborious examination to get a clear and coherent description or definition of “internal responsibility” from witnesses Albert McLean, John Smith, Fred Doucette, Claude White, Jack Noonan, and Hugh Macdonald. It was clear from the testimony that the inspectors, from the most senior level, had a reasonable understanding of the responsibilities of miners and operators; it was also clear that they shied away from any hands-on involvement in ensuring that those responsibilities were carried out. It almost appeared that to them the application of the IRS and regulatory enforcement were mutually exclusive. To this extent, the evidence of the department regulators suggests an abdication of the responsibilities and duties set out in the *Coal Mines Regulation Act* and the *Occupational Health and Safety Act*. After hearing “internal responsibility” described by these witnesses, I was compelled to make the following comment to Macdonald: “What I have heard over the last couple of weeks . . . leaves me with the impression that the internal responsibility system provides a very neat vehicle for the inspectorate to dodge their responsibilities.”⁸⁰ As a result of subsequent research and consultations with mining engineers from other jurisdictions, my impression of the internal responsibility system has changed. What has not changed is my impression as it relates to the Department of Labour in Nova Scotia.

Department of Labour personnel seem to have looked upon their role in mine safety generally as one of education and training. As deputy minister Macdonald said:

We believe strongly in the internal responsibility system, but in hindsight it begs the question whether more could have been done to make employers understand really what that meant and their responsibilities under that system. . . . perhaps even a greater educational effort with the inspectors themselves. . . . We did do a fair amount of advertising early on in trying to acquaint people that there was new legislation [*Occupational Health and Safety Act*]. Whether or not that went far enough . . . to make people fully understand their responsibilities, that may be a moot point. And I would suggest that one of the things that maybe needs to be revisited is the question of training or educating the parties in the workplace.⁸¹

Jack Noonan acknowledged at the hearing his responsibility for the administration of the *Occupational Health and Safety Act* and the safety aspects of the *Coal Mines Regulation Act*. In my view, it was Noonan’s

⁸⁰ Hearing transcript, vol. 70, p. 15324.

⁸¹ Hearing transcript, vol. 70, pp. 15287–88.

non-interventionist interpretation of the theory of internal responsibility that permeated the inspectorate. His attitude is clear from his evidence:

Well, internal responsibility means that everyone takes the responsibility for themselves and their fellow workers. That it's a cooperative venture primarily between management and labour. That's where it starts. The people who actually do the job and are responsible for having the job done share the responsibility for the safety and health in the workplace.⁸²

When asked about the responsibility of government, and specifically that of the government of Ontario with which Noonan was familiar, he again stressed the non-interventionist role: "My perception at that time, and it probably still is, was that the government was a facilitator, that they aided and assisted in interpretation. They provided help with their experience in other operations . . . [a]nd, of course, they audited for non-compliance of the act." These statements appear to suggest that the principal role of government is not inspection and enforcement but a more passive role – facilitating and assisting. Noonan seems to equate inspection and enforcement with policing and, as such, not consistent with internal responsibility: "They [inspectors] have an audit function."⁸³ It may turn into a policing function. And if it does, then we've failed in handling it. And certainly the internal responsibility section of it has to be brought back into play if anything is going to work." Noonan asserted that the IRS is in place in "almost every jurisdiction in Canada and in North America."⁸⁴ He expressed his understanding that the system had been adopted in a number of states in the United States, but he professed ignorance of the fact that the United States, Ontario, and British Columbia had specialized training programs for their mine inspectors.⁸⁵

The transcript of Noonan's testimony is replete with inconsistencies, contradictions, and inaccuracies such as those outlined above. Nothing would be served by repeating more examples. He was the person charged with the responsibility of administering the safety and health legislation in the Department of Labour. His evidence discloses that he was lacking in either ability or motivation for the task. His interpretation of the internal responsibility system only reinforces the impression I gleaned from the evidence of the inspectorate. I am unable to say with certainty whether his interpretation indicates a fundamental misunderstanding of the role of the inspectorate or was merely a clumsy attempt to distance himself and his inspectorate from any fault or censure respecting the events leading up to the 9 May explosion.

⁸² Hearing transcript, vol. 69, p. 15065.

⁸³ "Audit" in this context seems to be a euphemism for inspection, albeit milder and with less of the regulatory connotation.

⁸⁴ Hearing transcript, vol. 69, p. 15111.

⁸⁵ Hearing transcript, vol. 69, pp. 15205–06.

Finding

Jack Noonan, as executive director of occupational health and safety, held a perspective of the internal responsibility system inconsistent with usage in other jurisdictions and with the statutory obligations of the inspectorate. This passive and apathetic approach sent two messages to those in the inspection service: (1) that health and safety were primarily the responsibility of employer and miner; and (2) that the inspectors' role was one of training and persuasion, to be undertaken usually in response to the initiative of management or workers. For whatever reason, Noonan virtually abdicated any leadership role and must bear substantial responsibility for the failures of the inspectorate.

Although this finding may seem harsh, it is well supported by the evidence presented to the Inquiry. Despite his paper credentials, Noonan exhibited a startling ignorance of the practices and policies in other jurisdictions. He also seemed to allow his supervisors a degree of autonomy that effectively prevented him from directing his inspectorate in accordance with the governing legislation. Noonan was dismissed from his position and from the department several months after the 9 May explosion.

Claude White's responses at the hearings to questions respecting the IRS seemed intended to confound rather than enlighten. His evidence on this subject is best summarized in the following exchange between him and Inquiry counsel:

- Q. . . . [C]an I sum up the real essence of your testimony by saying that we can draw two conclusions from it . . . that we are now in a system of internal responsibility, but that there is still a great deal of confusion as to exactly what that means for the role of a mines' inspector inspecting mines. Is that fair?
- A. I would agree with that and I would look forward to the Commission trying to help us out in that area.
- Q. And . . . you will acknowledge that there has been indeed a failure of the regulatory system at Westray?
- A. I believe there was a failure in the system in terms of not achieving true internal responsibility, yes.⁸⁶

There is no magic or mystery in the so-called internal responsibility system. I am inclined to agree with the comment of John Laffin, retired deputy minister of natural resources for the province. In discussing the concept with Laffin, Inquiry counsel asked, "It's more or less something that always existed, but all of a sudden it had a title attached to it?" To which Laffin replied, "That's right. . . . [I]t always was there."⁸⁷

James Ham and Kevin Burkett, in their seminal reports on the Ontario mining industry, have done a great service in articulating the respective responsibilities of management, workers, and regulators and by

⁸⁶ Hearing transcript, vol. 64, pp. 14235–36.

⁸⁷ Hearing transcript, vol. 70, p. 15418.

consolidating these responsibilities under the readily understandable “internal responsibility.” My intention here is simply to show how such a simple and common-sense concept can be corrupted and rendered ineffectual. There is little that this Inquiry can do to clarify further the internal responsibility system. It has been well articulated by Ham, by Burkett, and by the numerous brochures and circulars prepared and distributed by the Occupational Health and Safety Branch of the Ontario Ministry of Labour.

A well-established practice of industrial safety supports the IRS and delineates the respective duties of the operator (represented by management), the worker, and the regulator. I have borrowed from the fire triangle in the Explosion chapter (see figure 6.3) to illustrate how each of the three industrial components must function together to achieve mine safety. This relationship is shown here in figure 12.1. One mining engineer told me that the job of the mining inspector is to so inculcate the concept of internal responsibility into management and worker that the inspector will virtually become redundant.⁸⁸ This is done through training, through supervision, through inspection, and, where necessary, through vigorous prosecution. In these respects, the regulators in Ontario are not that far removed from the inspectorate administered by MSHA in the United States. If there is a weakness in the system as proposed by Ham and further defined by Burkett, it is the lack of emphasis on the regulatory function, at least in the early stages of the IRS. Ham recognized the need for auditing the IRS “because it is a human organization in which conditions of work and concern for the well-being of persons create grounds for tension.”⁸⁹ Thus external auditors, including mining inspectors, were necessary. The IRS as described by Burkett encompassed the combined concepts of *direct* and *contributive* responsibility. The regulatory role of the inspectorate appears to be subsumed in the contributive aspect, and compliance with the *Occupational Health and Safety Act* and its regulations seems to be assumed. In 1988, the role of the inspectorate was further defined by the Ontario Standing Committee on Resources Development chaired by Floyd Laughren:

The Committee wishes to emphasize that the IRS must not be viewed by the parties as a “stand alone” initiative. To work properly it must be supported by other initiatives such as appropriate enforcement of legislation and regulations by government . . .⁹⁰

What follows is a brief analysis of the internal responsibility system as it is administered in the Province of Ontario.

⁸⁸ Conversation with Ian Plummer, recently retired provincial coordinator, mining, with the Occupational Health and Safety Branch, Ontario Ministry of Labour. Plummer also contributed greatly to the section in this chapter devoted to the Ontario system, which, of course, is based in large part on the Ham and Burkett reports.

⁸⁹ Ham Report, 152.

⁹⁰ Ontario, Legislative Assembly, Standing Committee on Resources Development, *Report on Accidents and Fatalities in Ontario Mines* [Toronto: Ontario Legislature, 1988] (Floyd Laughren, chairman) [Laughren, *Report on Accidents*].

Figure 12.1 The Components of Mine Safety

Internal Responsibility in Ontario

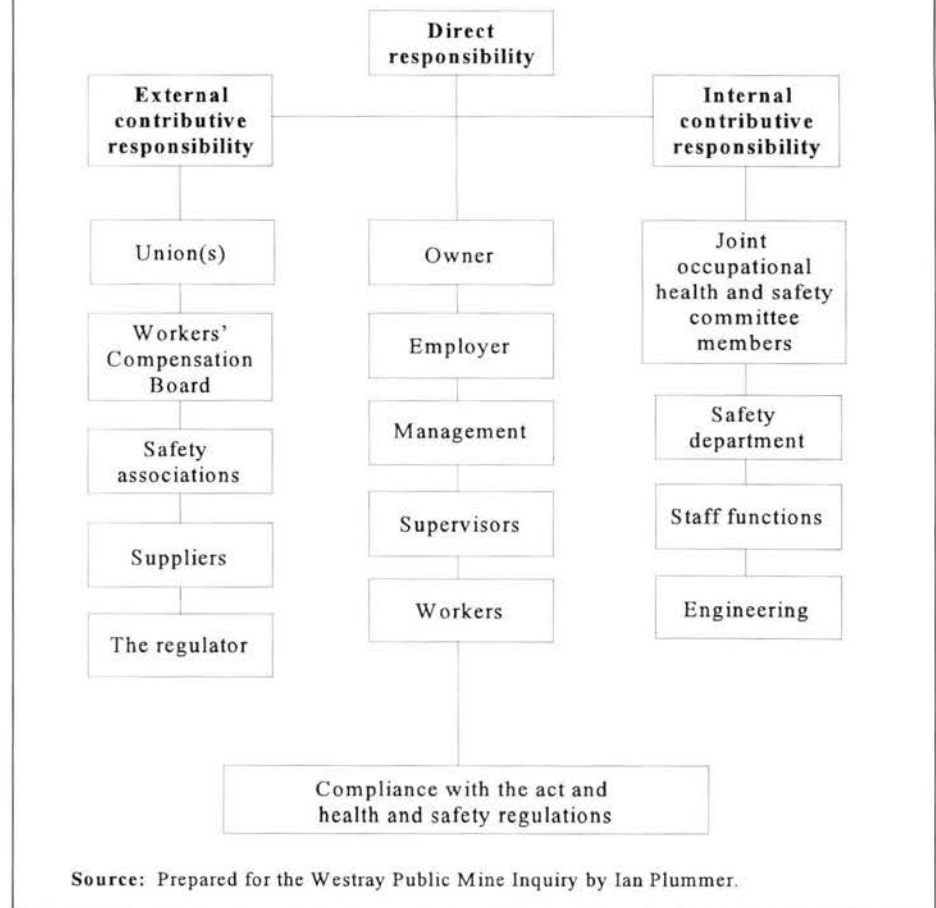
The term internal responsibility system is used in Ontario to describe the legislated rights and responsibilities of the workplace parties regarding health and safety in the workplaces of the province. It implies that there is a set of values, beliefs, and attitudes in the workplace, and that there will be meaningful cooperative action to resolve health and safety issues. It applies in particular to those who have *direct* control of conditions and practices in the workplace, from the chief executive officer (CEO) to the worker. The whole line of management (CEO, site manager, several levels of supervisors) and the workers are responsible, all in their own ways, for the health and safety of workers in the workplace. Thus, having a safe and healthy workplace is the responsibility of everyone concerned, not just the safety department.

Other groups, both internal and external, have *contributive* roles to play. Some key contributive players, who act as a kind of safety net, are the joint health and safety committees (JHSCs), unions, and government inspectors.⁹¹ Figure 12.2 depicts the various elements involved in the IRS.

Direct Responsibility

The chief executive officer sets the tone and ensures that safety and health are given priority, creating the framework for safe production. The CEO establishes the purpose of the enterprise, selects the manager, determines overall policy, arranges for the money to construct facilities and buy equipment, and reports to the shareholders on the state of the operation. To a large degree, these are the responsibilities of the owner under the

⁹¹ The Ontario *Occupational Health and Safety Act*, RSO 1990, defines and specifies the duties of “owners,” “employers,” “supervisors,” “workers,” “suppliers,” and “inspectors” with respect to workplace health and safety. It also mandates the formation of joint health and safety committees.

Figure 12.2 Internal Responsibility System

Ontario Occupational Health and Safety Act. One of the duties of an employer is to prepare a written occupational health and safety policy, and to review it each year. This duty is normally shouldered by the CEO as part of setting the tone.⁹²

The manager puts the corporate plan and the health and safety policy into action. The manager lays out the plan to achieve the corporate objectives (including health and safety); selects competent people as supervisors; assigns duties, authority, and responsibilities; sets operating policies; establishes and maintains communications to all levels at the site; provides facilities, machinery, and equipment; and evaluates progress in achieving the objectives. The manager, although technically a supervisor under the act, must make sure that the employer's responsibilities have been carried out. These include maintaining facilities and equipment; ensuring safe use of the facilities and equipment; providing information,

⁹² **Comment** In spite of his protestations to the contrary (as reported in the media on many occasions), there is no testimony or documentation before this Inquiry that would even suggest that Clifford Frame, chief executive officer of Westray, made any effort to "set the tone and ensure that safety and health are given priority." There is no evidence that Frame prepared a "written occupational health and safety policy" to show by example that safety is paramount.

instruction, and supervision to workers; and, in general, taking all reasonable precautions for the protection of workers.⁹³

Supervisors (particularly first-line supervisors) are a key link in the chain. They assign the work; instruct and develop workers; coordinate and direct the work, ensuring that the policies, procedures, and regulations are observed in order to maintain healthy and safe conditions; arrange for adequate equipment and supplies; and report on progress and anomalous conditions. They represent management to workers, and to some degree they represent the workers to management. Their example, influence, and authority are essential in shaping worker attitudes and in ensuring worker compliance with safety and health policies. This influence is vital, as workers must continue to work safely in the absence of a supervisor.⁹⁴

Under the act, supervisors are responsible for ensuring that workers work in accordance with the act and regulations, and with the required protective equipment. They must also advise workers of hazards and take every reasonable precaution in the circumstances. Where a worker reports that he or she is endangered or that another worker is endangered by continuation of the work, the supervisor has a duty to investigate the circumstances, as quickly as possible, with the worker and a worker representative. Clearly, this imposes the duty on supervisors to try to resolve workers' concerns and to have safe work resumed.

The workers carry out the assigned duties, using knowledge, skill, and the policies and procedures for the workplace. Because the work in an underground mine takes place largely with no supervisor present, workers have to take initiative within the envelope of the safe working procedures and regulations, and they must coordinate with other workers. They are responsible for keeping the workplace in a safe condition, for using the facilities and equipment in a safe manner, and for reporting to supervisors on hazardous workplace conditions or equipment.

If workers are to be responsible, they must also have rights:

- the right to know (that is, to be informed of the hazards in the work, and to be trained to carry out the work)
- the right to participate (both directly in the workplace and through the joint health and safety committee)
- the right to refuse work that endangers themselves or other workers.⁹⁵

Contributive Responsibility

Under the Ontario act, each workplace with 20 or more workers must have a joint health and safety committee (JHSC). (There are some exceptions

⁹³ The sharp contrast between this description of a manager's responsibilities and the behaviour of Gerald Phillips at Westray well illustrated in Chapter 3, Organization and Management at Westray.

⁹⁴ This description is certainly at odds with the reality of supervision at Westray, as detailed in Chapter 3, Organization and Management at Westray.

⁹⁵ These rights were effectively denied the workers at Westray, as is well documented throughout this Report.

and also some circumstances where a committee is needed with fewer than 20 workers.) The act sets minimum standards for the committee, in terms of size and frequency of meeting, and requires that at least half the members be workers. Smaller workplaces – with six or more workers – require a worker health and safety representative.

The representatives of the workers are selected by the union or unions representing the workers or, if there is no union, by the workers themselves. The union or unions have a responsibility to provide members for the joint health and safety committee; an effective IRS needs the support of the unions. The role of worker representatives in the IRS is to give the workers a group voice in the formulation of health and safety policy and programs. That voice should be heard on new facilities, equipment, and processes; on the setting of safety goals; on the effect of management policy on health and safety issues; and on the general health and safety condition of the workplaces.

Under the act, the joint health and safety committee has the right to have members inspect the workplaces and to investigate serious accidents; to receive relevant information from the employer; to make recommendations to management; and to receive a reply to the recommendations within 21 days.

The inspectors of the Ministry of Labour have a contributive role too. During their inspections, investigations, and audits, they evaluate how well the IRS is working, and whether decisions made between the workplace parties are appropriate. If the IRS is malfunctioning, the inspector has to take action. Such a malfunction could be the failure to correct a legitimate health or safety situation, either because agreement cannot be reached, or because the agreement reached does not meet the minimum requirements of the regulations. If the workplace cannot resolve a work refusal under the act, the inspector is required to make a decision on whether or not there was a danger. If a contravention of the regulations persists, a correction order must be issued, with a required compliance period.

If an inspector's correction order is needed, the internal responsibility system has failed. If the IRS at a workplace consistently fails, more attention is needed by the inspectorate. This attention entails more inspector visits – including inspections, audits, investigations, and senior level contacts among the ministry, the employer, the union, and the JHSC.

The Ontario Ministry of Labour has an objective of greater self-reliance in workplaces. Indications of self-reliance are: a consistent compliance with the minimum standards set by the regulations; a striving for ethical compliance (that is, over and above the requirements of the regulations); and a general lack of serious accidents, complaints, and refusals to work. Inspectors then concentrate on those workplaces that are in consistent non-compliance with the regulations, that have an accident rate above the average for similar workplaces, and that have legitimate complaints and refusals to work.

As Floyd Laughren commented, “Failure to make IRS work properly, coupled with continuing high fatality rates, may prompt the government to look more favourably upon alternatives to IRS.”⁹⁶

Internal Responsibility in Nova Scotia

In its brief to this Inquiry, the Nova Scotia Department of Justice stated:

The Westray Commission could make a significant contribution to Nova Scotia’s achievement of the IRS vision, in building on the work of prior commissions, specifically by:

- clarifying what IRS means, and how it must function to accomplish a safer workplace,
- identifying any weaknesses in how each internal and external party performed its role in relation to the Westray mine, and
- making recommendations that will address weaknesses disclosed by the evidence, as was done in the Burkett report.⁹⁷

Some of these matters will be addressed in other parts of this Report. This section of the Report provides a brief analysis of the internal responsibility system and how it was misinterpreted and misapplied by the Labour inspectorate in Nova Scotia.

Finding

It is abundantly clear that the provincial inspectorate used the concept of the internal responsibility system to divert attention from its own responsibilities. It is not so clear whether this was done as a matter of practice or after the fact to justify many of the deficiencies of the inspectorate, which only became apparent after the explosion of 9 May 1992.

The IRS is not a complex concept. It is a way of describing what ought to be done in the workplace to ensure safety – and by whom it is best done. It is not a panacea for all industrial safety deficiencies, nor is it a substitute for a comprehensive and aggressive inspection program aimed at assuring compliance with the rules.

The Department of Justice’s submission goes on to state at page 33:

IRS is now recognised widely as the best approach to workplace safety. IRS is not a way out for the inspectorate. It arises from the recognition that government inspections will never be enough no matter how thorough and frequent. Inspections may in fact stifle development of the climate that is necessary for a significant shift in attitudes towards safe practice.

These are extravagant and largely unsupported statements. Workplace safety is pursued in many ways and different terms are used in its description. IRS is one way of describing an approach that, if accepted and

⁹⁶ Laughren, *Report on Accidents*, 19.

⁹⁷ Department of Justice, Submission of the Province of Nova Scotia to the Westray Mine Public Inquiry, 9 August 1996, 32.

applied by operators, workers, and regulators, could be a significant factor in improving industrial safety.⁹⁸ It is trite to say that IRS is “not a way out for the inspectorate,” but the suggestion that it was used precisely in that way at Westray is supported by the evidence at the hearing. I find no support for the bald statement that “inspections may in fact stifle development of the climate that is necessary for a significant shift in attitudes towards safe practice.” From my research and investigations, I suggest that the coal mining industry in the United States, operating with the massive inspection presence of MSHA, belies that assertion.

I now return to a review of the evidence respecting the performance of the inspectorate at Westray.

The Inspectorate at Westray

The inspectors were not ready to regulate safety at Westray, as John Smith agreed. They had no formal training in inspection or experience with modern, mechanized room-and-pillar operations. By the time Westray was proposed, Smith was already dealing with a variety of matters beyond his training and expertise. He tried to keep up to date by reading technical journals, but it had been at least 15 years since he had inspected a coal mine.⁹⁹ McLean considered that he and the other inspectors were at a disadvantage in dealing with Phillips and the mining operations at Westray.¹⁰⁰

For the most part, Albert McLean was not willing to accept all the statutory responsibilities assigned to an inspector under the *Coal Mines Regulation Act*. He knew that he had powers under the act and he felt competent to do all that was required, but he did not accept responsibility for ensuring compliance with many sections of the act. McLean’s own evidence discloses some serious shortcomings in his performance:

- He had only a rudimentary knowledge of mine ventilation.
- He could take gas readings at accessible locations but did not acknowledge that more than this was necessary.
- He did not measure airflow.
- He said that he did not understand series ventilation or methane layering.
- He could not competently review ventilation plans or the adequacy of auxiliary ventilation fans.
- He lacked the knowledge or ability to rule on the effectiveness of stoppings.

⁹⁸ For other ways of expressing similar concepts, see [United States], *Federal Mine Safety and Health Act of 1977*, section 2(e): “[T]he operators of such mines with the assistance of the miners have the primary responsibility to prevent the existence of such [unhealthful and unsafe] conditions and practices . . .” Also see International Labour Conference, *Proposed Convention Concerning Safety and Health in Mines*, Provisional Record 19A (Geneva, 1995), article 5, concerning “the supervision of safety and health in mines [and] the inspection of mines by inspectors designated for the purpose . . .”

⁹⁹ Hearing transcript, vol. 58, pp. 12683–87.

¹⁰⁰ Hearing transcript, vol. 55, pp. 11945–47.

It is impossible to determine how much of McLean's unwillingness was the result of the hands-off policy espoused by his superiors and how much was self-motivated. Indeed, some of his attitude may be attributable to an attempt, after the fact, to shrug off some responsibility.

As a professional mining engineer, Claude White should have detected and remedied deficiencies in the inspectorate. In some instances, he chose not to exercise his professional judgment. In other cases, he did not see the need for technical appraisal, or just got things wrong. Inquiry Ventilation expert Dr Malcolm McPherson referred to the significant failure to address concerns in the ventilation surveys provided to White:

Even a fairly cursory glance through those reports would have shown matters that should have stood out like red flags to mine enforcement officials. I refer to the high concentrations of methane that were reported.

I refer to the recirculation, the uncontrolled recirculation that was occurring in the north workings. These are matters that should have resulted in fairly rigorous action to rectify these matters.

I would suggest that the mine should have been subjected to sanctions because of these infringements against the law and going beyond that, because of the disregard for safety that seems to have been the philosophy at Westray. And those actions may well have started with warnings, formal warnings, followed by more stringent sanctions, citations, and followed up, if necessary, if no action is taken, by a stop work order. And indeed, in cases of perceived immediate danger, there again, stop order, stop work orders may well have been issued.¹⁰¹

Such actions are the substance of the responsibility of the inspectorate to the underground miner. This responsibility cannot be ignored, nor can it be sloughed off by recourse to some distorted concept of internal responsibility. The responsibility was that of the inspectorate – and the inspectorate was found wanting.

One December 1991 survey indicated the use of recirculated air to heat the main ventilation air.¹⁰² This recirculation was a matter of some concern, and had been discussed by Westray officials and the inspectors. White said he had no idea if the company ever recirculated main return air. White did nothing to confirm or deny approval for such recirculation, although he recognized that his department had the responsibility to ensure appropriate safeguards.¹⁰³

Applying the Regulatory Regime

The legislation under which the Westray mine was developed and operated did not meet the regulatory needs of a modern coal mine. The *Coal Mines Regulation Act* is outdated. Little progress had been made in updating mining regulations to reflect modern technology before construction started at Westray. Noonan's directors had sought regulations consistent with the *Occupational Health and Safety Act* and current technology, but

¹⁰¹ Hearing transcript, vol. 9, pp. 1709–10.

¹⁰² Exhibit 37a.043.

¹⁰³ Hearing transcript, vol. 63, pp. 13982–87.

Noonan did not respond.¹⁰⁴ In his request to Noonan for additional technical assistance, White described the *Coal Mines Regulation Act* as “a tremendous burden on the Minister, the Chief Inspector and the Inspectors.”¹⁰⁵

The inspectorate faced further obstacles in enforcing the act. According to Smith and Doucette, the inspectors had problems getting supplies, such as test tubes for sampling diesel emissions, or maintenance for mine rescue equipment.¹⁰⁶ Inquiry ground control expert Dr Miklos Salamon told the Inquiry how easy it is for a regulatory regime to become a “rubber stamping” exercise where regulators lack resources to administer legislation in a meaningful fashion.¹⁰⁷

It appears that the inspectorate did not properly administer the *Occupational Health and Safety Act*. The inspectors’ descriptions of their responsibilities under that act suggest a limited grasp of the act. The Department of Labour did little to develop the miners’ involvement in the new regime, which was based in great part on the workers’ taking responsibility for their own health and safety. Smith left copies of the *Occupational Health and Safety Act* at the mine site,¹⁰⁸ and union organizers gave copies to some miners.¹⁰⁹ The inspectors made no effort to see that the miners understood the information or that Westray management complied with the law. Miners were generally not given copies of the *Coal Mines Regulation Act* and the *Occupational Health and Safety Act* by the company.

Communication with the underground workers was limited. Some testimony referred to customs in the coal mining industry that made it inappropriate to take complaints outside the company.¹¹⁰ McLean said that he always spoke to the miners as he travelled, though he noted it in reports rarely.¹¹¹ Most miners remembered McLean’s few words as casual greetings, not inquiry into conditions in the mine. McLean travelled with management, usually Roger Parry.¹¹² In general, the miners were hindered by the very presence of Parry with the inspector. As Smith put it, “[W]hat

¹⁰⁴ White (Hearing transcript, vol. 63, pp. 13796–98).

¹⁰⁵ Exhibit 141.01.054.

¹⁰⁶ Doucette (Hearing transcript, vol. 62, pp. 13620–21).

¹⁰⁷ Hearing transcript, vol. 14, pp. 2470–78.

¹⁰⁸ Hearing transcript, vol. 58, p. 12687.

¹⁰⁹ Bob Burchell (Hearing transcript, vol. 44, pp. 9628–30).

¹¹⁰ Jay Dooley told the Inquiry that neither he nor anyone he had ever worked with had gone directly to a mine inspector with a complaint. He would always “follow the chain of command” (Hearing transcript, vol. 38, pp. 8424–30).

¹¹¹ One instance had been in August 1991, when he recorded that he warned workers to make sure the workplace was secure (Exhibit 139.01.45); another in March 1992, when he reported that he had spoken to workers in each section, with “no problems” noted (Exhibit 73.06); another when he spoke with safety committee member Owen McNeil (Exhibit 73.08.015); and another when he met with three safety committee members (Exhibit 120.306).

¹¹² When asked by Inquiry counsel if he was always accompanied by management, McLean replied, “I’d say, yes” (Hearing transcript, vol. 55, p. 12049).

are you going to find out anywhere if you've got someone like Roger standing right next to you . . ."¹¹³

McLean denied that miners were inhibited by the presence of management. That had not been his own experience as a miner.¹¹⁴ White said that complaints of intimidation and discrimination against an employer under section 25 of the *Occupational Health and Safety Act* were handled by another division of Labour and was not the business of the mine inspectors. He said miners would have had to take complaints about Parry's threats or management reprisals to that other division.¹¹⁵

McLean claimed, "[N]o men came to me and told me what way Westray treated their men. . . . Nobody."¹¹⁶ This is not consistent with other evidence. A number of miners complained to McLean during inspections or outside the mine, and McLean failed to follow up. Any lack of complaints may have resulted from Labour's failure to respond to those that were made. Labour's response to individual complaints is illustrated below, in the section on the Carl Guptill saga.

The treatment of Westray's safety committee, a key component of the *Occupational Health and Safety Act*, shows the inspectorate's handling of its role to be deficient. The inspectors had assisted other companies in providing training for members of occupational health and safety committees.¹¹⁷ They did not do so at Westray. In a 4 September 1991 meeting with Westray management, White said that the safety committee should take part in investigating "unusual occurrences," such as injuries or roof falls.¹¹⁸ The inspectorate did not emphasize that point with the committee.¹¹⁹ The committee received little cooperation from the company, at times learning of accidents or other incidents through word of mouth.

Neither the company nor the inspectorate sought input of underground workers in decisions affecting safety; nor did they invite participation by worker representatives in the mine inspections. McLean told the Inquiry that Noonan instructed the inspectorate to "leave the safety committee all alone." If "there are no problems," inspectors were not to contact the committee, even to give notice of impending inspections.¹²⁰ White said "there was a perception in the Department, perhaps," that having safety

¹¹³ Hearing transcript, vol. 59, pp. 13056–57.

¹¹⁴ Hearing transcript, vol. 55, p. 12050.

¹¹⁵ Hearing transcript, vol. 64, p. 14148. **Comment** I wonder how the miners were to know of this condition, since the act was not explained to them and the act itself does not specify the departmental organization. Apart from one brief visit to the site by an occupational hygienist, there is no evidence of any other Department of Labour presence at Westray.

¹¹⁶ Hearing transcript, vol. 55, p. 12057.

¹¹⁷ Carl Guptill told the Inquiry that, while at the Forest Hill mine, he had been sent to a seminar "that more or less had us set up and run a safety committee" (Hearing transcript, vol. 29, p. 6134).

¹¹⁸ Exhibit 73.08.003.

¹¹⁹ White did not know of any meetings that his department had with the Westray safety committee other than McLean's meeting with the three members in January 1992 (Hearing transcript, vol. 63, pp. 13754–55).

¹²⁰ Hearing transcript, vol. 56, pp. 12154–56.

committee members on inspections was at the discretion of the inspectors.¹²¹ White said it was more efficient to speak to whomever one encountered in the mine than to ensure committee representation during inspections.¹²²

Committee members were not all aware that travel with the inspector was possible. Rick Mitchell, a miner who knew of this practice elsewhere, asked Roger Parry about travelling with McLean and was told “it wasn’t important,” that he “wasn’t needed.”¹²³ He did not realize that he was entitled to go with the inspector. Parry, as we have seen in Chapter 5, *Working Underground*, had threatened to fire anyone caught complaining to the inspectors.

We have also seen how the company responded inadequately to concerns of the safety committee, usually with excuses or a cursory clean-up of smaller problems. The safety committee repeatedly called for action on serious and recurring issues, such as dust accumulation and inadequate stonedusting. The company prepared both the safety walk reports and the meeting reports, and, on occasion, some observations by the committee were removed. The reports did identify safety concerns that should have gained the attention of the inspectorate. Claude White never looked at safety committee reports.¹²⁴ McLean said he had read at least three safety committee reports. Some members of the committee thought the inspector reviewed their reports to ensure that safety concerns were addressed. They learned that McLean had received them, but had done nothing.¹²⁵ McLean was satisfied by the company’s written responses that it was taking appropriate action.¹²⁶

Owen McNeil, a member of the safety committee, said that McLean had always asked him if he had concerns. McLean noted on 29 October 1991 that he spoke with McNeil and heard no complaints.¹²⁷ McNeil recalled that he had told McLean about a number of safety concerns, including inadequate stonedusting.¹²⁸ Other committee members had spoken with McLean. They said that they had informed him of serious safety problems.¹²⁹

There is only one recorded instance of McLean meeting with miners on the committee. Carl Guptill’s complaints in December 1991 had led to some discussion between Phillips and the department about the necessity for an inspector to meet with the committee to review its role.¹³⁰ A brief

¹²¹ Hearing transcript, vol. 63, p. 13762.

¹²² This was somewhat disingenuous of White, given his admission that his conversation with miners underground at Westray was extremely limited.

¹²³ Hearing transcript, vol. 31, pp. 6714–15.

¹²⁴ Hearing transcript, vol. 64, pp. 14216–17; vol. 60, p. 13149.

¹²⁵ Mitchell (Hearing transcript, vol. 31, pp. 6730–32).

¹²⁶ Hearing transcript, vol. 57, p. 12592.

¹²⁷ Exhibit 73.08.15.

¹²⁸ McNeil, Department of Labour interview, 29 October 1992, electronic file MACN-JO.DOL, pp. 35–36.

¹²⁹ Randy Facette (Hearing transcript, vol. 33, pp. 7264–65).

¹³⁰ For background, see the section on Carl Guptill’s experience later in this chapter.

meeting with three safety committee members took place at the mine site on 27 January 1992.¹³¹ They complained of serious and continuing safety concerns in the mine, and gave McLean details of safety violations. McLean sent White a memo, which spoke to only three concerns: qualifications for examiners, safe procedures for using torches underground, and approval for underground use of non-flameproof vehicles.¹³² McLean's memo failed to inform White of the urgent safety concerns testified to by Mitchell and Facette. He did not provide the committee members with copies of his memo.

Finding

The Westray joint occupational health and safety committee was given little assistance or encouragement from either the company or the inspectorate. The company clearly did not want an effective committee. The inspectorate, operating under Noonan's strange interpretation of internal responsibility, adopted a passive and non-interventionist approach, ensuring that the committee would be ineffectual.

Upgrading the Inspectorate

There is no evidence that competency of the inspectors assigned to Westray was evaluated when they were given their tasks. White attempted to upgrade the inspectorate. In January 1989, he wrote a memo to the minister that spoke of the "additional strain" put on the inspectorate by the new coal mine and the need for new inspectors.¹³³ In September 1991, he proposed hiring additional staff and training existing staff.¹³⁴ Smith thought they were getting a coal inspector based in Stellarton, and McLean later asked for a ground control consultant. White recommended to Noonan that the inspectorate engage a mining engineer to be based in Halifax. He wrote that relying on the Department of Natural Resources for technical assistance was no longer adequate. White said that he thought Noonan had generally supported his proposal even though Noonan directed him to rewrite it. Noonan's testimony suggests that Noonan was not convinced that additional professional help was necessary.

White told the Inquiry that the inspectors were not at a disadvantage in dealing with a high-tech mine. He did say that training had been deficient; he recommended improved operational training as well as core training in inspection at a recognized facility such as the National Mine

¹³¹ The three were Randy Facette, Owen McNeil, and Rick Mitchell.

¹³² Exhibit 120.306.

¹³³ Exhibit 139.15.001. White also outlined the problem of the disproportionate concentration of officers at the Glace Bay office, the confusion as to which set of regulations applied under the *Occupational Health and Safety Act*, and the possibility that requiring compliance with modern guidelines for acceptable levels of noise, dust, or noxious gases might mean mine closures and loss of jobs. This memo was stamped as received by the deputy minister of labour, but nothing seems to have come of it.

¹³⁴ Memo of 18 September 1991 to Noonan and discussion paper regarding staffing requirements for the inspectorate (Exhibit 141.01.050–59).

Health and Safety Academy at Beckley, West Virginia.¹³⁵ Instead, some in-house sessions, had been provided, along with video and written materials. According to Smith, the in-house training was largely related to “everything you could think of except coal mines.” This “training” was clearly inadequate.¹³⁶

Noonan did not respond directly when asked why the inspectors were not sent for training in specialized coal mine inspection. He had never assessed the competence of the inspectors.¹³⁷ He relied on Claude White’s evaluation of their performance.¹³⁸ Despite White’s staffing proposal, Noonan did not accept that White considered the existing inspectorate inadequate for the challenge of a major new coal mine. Noonan felt that the inspectors’ experience in Nova Scotia mines was adequate preparation for inspecting Westray: “[T]heir experiences are in coal mines and coal mines are coal mines, although within themselves, they change from area to area and time to time. And the occupational health and safety aspects of them are a basic thing.”¹³⁹ He said that the decision not to send the inspectors to Alberta to observe an operation similar to Westray was made jointly by himself, White, and Hugh Macdonald. In his opinion, safety officers did not need to know the equipment and operations at a work site in order to fulfil their role.¹⁴⁰ He felt that an unsafe operation or practice would be obvious to an experienced miner.¹⁴¹

John Laffin was the deputy minister responsible for the mine inspectors prior to their transfer to Labour. He recalled that the mine inspectors had come together to learn about a new continuous miner before it went underground at the McBean mine. Laffin thought inspectors needed to understand the mining methods and equipment used at sites they were to inspect.¹⁴² This is consistent with good business practice as well as common sense.

Hugh Macdonald said that he had never been made aware of requests for additional staff or training for the inspectors assigned to Westray. He knew that the supervisor position remained vacant after Colin MacDonald retired, but he assumed that the inspection unit had sufficient resources to do the job at Westray. According to Hugh Macdonald, if White had thought new staff was essential, he should have brought the matter beyond Noonan, to himself as deputy.¹⁴³

¹³⁵ Hearing transcript, vol. 63, pp. 13819, 13940–45.

¹³⁶ Hearing transcript, vol. 58, p. 12688.

¹³⁷ Hearing transcript, vol. 69, pp. 15099–15100.

¹³⁸ Hearing transcript, vol. 69, p. 15188.

¹³⁹ Hearing transcript, vol. 69, p. 15140.

¹⁴⁰ Hearing transcript, vol. 69, pp. 15147–49.

¹⁴¹ Hearing transcript, vol. 69, pp. 15216–17. **Comment** The sum of Noonan’s evidence on these issues leads me to conclude that the man was completely out of touch with the realities of modern underground coal mining. His ignorance of the subject, coupled with a wilful and stubborn blindness to the needs of his inspectorate, had a deleterious effect on the inspectorate.

¹⁴² Hearing transcript, vol. 70, pp. 15428–29.

¹⁴³ Hearing transcript, vol. 70, pp. 15318–19.

Pattern of Inspections

The record shows that the mine inspectorate recognized the issues that needed to be addressed in a safe mining operation. The inspectorate may have recognized the issues, but it did not address them in any meaningful manner. It is clear that the inspectorate deferred to the company and tolerated repeated promises and delays instead of insisting on performance. Prior to the start of the Westray access tunnels, the mine inspectors had met with company representatives, first from Suncor and then Westray. While with Suncor in 1986, Phillips worked out a draft of safety precautions with Walter Fell and Pat Phelan to address the risks involved.¹⁴⁴ In February 1986, Albert McLean and Colin MacDonald reviewed the draft Manager's Fire Precaution Plan and Manager's Auxiliary Ventilation Plan for both rock tunnel and coal driveage.¹⁴⁵

By the time the contractors broke ground at Westray, the inspectorate had already met with Phillips to get an overview of the project.¹⁴⁶ The developers initially claimed that the rock tunnel driveage was not subject to the *Coal Mines Regulation Act*. White disagreed because of concern that the tunnelling would encounter methane in shallower seams before reaching the areas of commercial production.

In a letter to White dated 21 December 1988, Phillips requested exemptions from the *Coal Mines Regulation Act*, to permit the use of uncertified equipment, explosives for blasting the tunnel, and hard-rock miners instead of trained coal miners.¹⁴⁷ He also provided the inspectorate with the Manager's Safe Working Procedures for the Westray mine that December.¹⁴⁸ This document set out the fire precaution and auxiliary ventilation plans for the mine, as well as procedures for stopping and starting fans, and for stonedusting. Much of the content was taken from the legislation and consists of generalities about objectives rather than details of how they would be accomplished. On 17 February 1989, White granted the exemptions for the operation of mobile equipment, subject to conditions for ventilation and monitoring methane and carbon monoxide levels.¹⁴⁹ The exemptions were granted for the duration of the rock tunnel driveage only.

Colin MacDonald recalled that Phillips got upset when MacDonald repeatedly brought up the gas risk.¹⁵⁰ At their first meeting, John Smith asked Phillips about methane drainage. Phillips apparently said, " 'Oh, there's no gas.' " ¹⁵¹ Smith was surprised by Phillips's attitude towards the methane hazard. Smith expected that someone with a British Coal

¹⁴⁴ Exhibit 69a.003.

¹⁴⁵ Exhibit 139.01.02.

¹⁴⁶ Exhibit 139.07.007.

¹⁴⁷ Exhibit 69a.010.

¹⁴⁸ Exhibit 37a.107.

¹⁴⁹ Exhibit 69a.022–28.

¹⁵⁰ Exhibit 139.01.47.

¹⁵¹ Hearing transcript, vol. 58, p. 12666.

background would consider this mine a prime candidate for methane extraction procedures, or degasification, given the evidence of methane emissions in Pictou County. As reported by Algas in 1981, the deeper the coal, the higher the methane content.¹⁵²

The hazards of mine gases are a known risk in coal mining. Records show that Labour recognized the necessity to manage this risk with sound engineering and good mining practices, just as it recognized most major issues. If the inspectorate recognized a need for careful, correct treatment, how and why did it come to miss the concerns within its range of competence, or fail to enforce compliance in the cases of problems detected? In hindsight, we can see a pattern emerging in the interactions between Labour and the company from the early stages of the project, with Labour showing a remarkable willingness to accept the company's version of events and issues, and an unreasonable patience in waiting for company action on the few matters put to it for correction. The department made regular concessions about the standard of performance required, and waited for the company to correct inadequate performance and unsafe practices.¹⁵³

Throughout the short life of the mine, the inspectorate narrowed its scope of inquiry or, through indifference and incompetence, ignored evidence of serious problems. It did not take appropriate measures to enforce compliance, despite evidence that the company was not meeting requirements. Inspectors occasionally caught the company in violation of regulations, or made a perfunctory response to worker complaints, which resulted in Labour's bringing the subject up for discussion in meetings with management. Sometimes members of management made promises or excuses; sometimes they merely postured. Generally, Labour accepted company assurances that concerns would be addressed and promises kept, even after months of delays and excuses. In rare cases where an order was issued, Labour's follow-up was inadequate. The delays permitted for curative action were unacceptable, given the serious threats to safety.

The manner in which the mine safety officers conducted their inspections may have made it easier for them to miss some of the problems in the mine. The inspections were brief, they took place in the presence of management during the day shift, and the inspectors did not review the shift reports or each other's reports in a systematic and comprehensive way.

The inspections lasted only three to four and half hours at most, including travel up and down the mains.¹⁵⁴ None of the inspectors stayed long enough in one work area to observe important aspects of the operations. My exposure to the MSHA inspection practices left an entirely different impression. When dealing with a new coal mine or with errant

¹⁵² Algas Resources Ltd, "A Coalbed Methane Content Evaluation of the Pictou Coalfield – Pictou Co., Nova Scotia" (1981), p. 51 (Exhibit 73.03).

¹⁵³ For detailed accounts of these interactions, see Chapter 5, Working Underground at Westray, Chapter 9, Dust, and Chapter 10, Ground Control.

¹⁵⁴ McLean (Hearing transcript, vol. 56, p. 12135)

mine management, the inspector may actually “camp” on site and pursue compliance relentlessly until satisfied. An inspector may spend several weeks at a mine and even enlist the aid of more specialized professionals. I sensed the same sort of thoroughness in the regulatory schemes of British Columbia and Ontario.¹⁵⁵

Singly or in small groups, the inspectors checked some portion of the Westray mine site nine times in 1989, 10 in 1990, 24 in 1991, and six times in the first four months of 1992.¹⁵⁶ Albert McLean made site inspections 17 times in 1991 and five times in the first four months of 1992. Some trips were surface or single-purpose inspections, to look at a roof fall or a particular piece of equipment. Other trips were for meetings with Westray management.

White’s 1989 memo to the mine safety officers on work activity plans for 1989–90 specified that frequency of visits should be based on statutory requirements, accident occurrence, and number of violations.¹⁵⁷ Section 63(2) of the *Coal Mines Regulation Act* requires that an inspector look at every travelling road and every working section of every mine in his appointed district at least once a month. McLean barely complied with the minimum frequency requirement and he noted his travel routes; he did *not* inspect every road and section every month. Doucette, because of his health, seldom travelled underground. He went underground a few times to look into mine rescue matters and to accompany other inspectors. Smith inspected the tunnels during early development. As McLean assumed responsibility as coal inspector, Smith went underground less frequently and concentrated on particular pieces of gear.¹⁵⁸ When a group of inspectors went to the mine, Smith tended to go with maintenance supervisors Bob Parry or Brian Palmer to inspect equipment underground or on surface while the others travelled underground with Roger Parry or Phillips.

White travelled the mine at most four times a year, and his travel routes were limited. He went to No. 9 Cross-cut on 3 September 1991 and noted coal dust accumulations and inadequate stonedusting. He went to No. 5 Cross-cut on 12 December 1991 to look at “a specific issue.” He did not get into the working areas until 29 April 1992, when orders were issued for action on the dust problem.¹⁵⁹

¹⁵⁵ Expert witness Andrew Liney estimated that “[i]n a mine as tiny as this, he [the mine inspector] would have walked around the whole piece in two days, maybe one . . . It depends on how energetic he was” (Hearing transcript, vol. 19, p. 3558). Liney went on to describe the rigour with which a typical British mine inspector might have approached the Westray mine.

¹⁵⁶ Exhibit 141.02.015.

¹⁵⁷ Exhibit 139.01.05.

¹⁵⁸ Westray underground worker Jonathan Knock testified that he had a conversation with Smith a month or two before the explosion in which Smith said that he was not going underground again because “he was retiring in three months and he wanted to live to spend his nest egg” (Hearing transcript, vol. 26, p. 5294). Albert McLean testified that he had received an anonymous telephone call about Smith’s no longer travelling underground at Westray and had informed White about the call (vol. 57, pp. 12497–500).

¹⁵⁹ Hearing transcript, vol. 63, pp. 13865–66.

The inspectors usually gave management a couple of days' notice of an inspection. In early 1991, a few days after McLean had reported concerns about roof conditions at Westray, he returned to the mine with White and Colin MacDonald. McLean told the Inquiry that Phillips became "a little hostile" with White and that "their voice was high." Apparently, White's presence at the mine was unexpected and unwelcome to Phillips. According to McLean, Phillips told the inspectors that he had just learned of White's impending visit from Pat Phelan, the director of mining engineering in the Department of Mines and Energy.¹⁶⁰ This was one of many incidents of Westray management's being abusive to the inspectors.¹⁶¹

Phillips asked for notice of inspections in March 1989, before mining began, to ensure that senior management would be available to accompany the inspectors.¹⁶² The inspectors agreed that the presence of someone in authority was required if the inspectors noted any unsafe condition or practice. Various witnesses testified that Westray management took advantage of the notice to hide localized safety violations or even to arrange some stonedusting along the proposed inspection route. A few miners thought that McLean may have been fooled by this, but most thought an experienced coal inspector would not be so deceived. Even with notice of inspections, management allowed conditions such as ventilation deficiencies and poor housekeeping to persist.¹⁶³

Finding

The inspectorate normally gave Westray management notice of its impending inspections. By so doing, the inspectors could not be assured that the conditions they encountered truly reflected the regular condition of the mine.

RECOMMENDATION

- 54 Visits by the inspectorate to the industrial site should not always be subject to prior notice. The inspectorate should schedule visits irregularly, and the operator should expect inspections at any time. Frequency of visits should be dictated by the safety performance of the operator.

¹⁶⁰ Hearing transcript, vol. 56, pp. 12204–09. Although McLean's testimony on the subject was guarded, I inferred that Phillips was abusive to the inspectors.

¹⁶¹ Smith told of a couple of occasions when management exhibited such behaviour. (Hearing transcript, vol. 58, pp. 12703–07). Doucette told of Roger Parry ranting and raving at White (vol. 62, pp. 13640–42). This is consistent with what appeared to be the practice at Westray – for management to be abusive to whoever got in its way – whether employees or inspectors. Phillips seemed to have an intractable attitude that this was his mine and he would operate it his way. The results speak for themselves. Rather disturbing also is the notion of a senior government official, Phelan, gratuitously giving advance notice to Phillips of an impending inspection by the mine safety officials.

¹⁶² Exhibit 139.05.10.

¹⁶³ These points are all documented elsewhere in this Report. See in particular Chapter 5, Working Underground, and Chapter 7, Ventilation, and Chapter 9, Dust.

The practice of travelling with senior site management meant the inspectors always visited the mine during the day shift. In testimony, Smith seemed to suggest that the inspectors considered that there was a possible risk of hazardous shortcuts, such as violation of the restrictions on non-flameproof vehicles, being taken during the night shift when workers were tired and fewer supervisors were around. None of the inspectors ever checked on it.

Finding

Department of Labour inspectors were regularly accompanied by management on their inspections. One consequence was to discourage the miners from discussing conditions with the inspectors. Workers underground did not have open communication with the inspectors.

The presence of management also meant that the route of an inspection could be influenced or determined by management. The inspectors did not know their way around Westray and did not review up-to-date mine plans before travelling. The inspectors depended on management to guide them. To the best of Trevor Eagles's knowledge, "the inspectors were never up in the engineering office talking to anybody in that office."¹⁶⁴ There was no signage underground, and the company's naming of particular roadways or headings was inconsistent and subject to change. Although the mine layout was relatively simple up to the time of the explosion, inspectors could not always describe where they had been or pinpoint locations of things observed within the mine. White admitted to not knowing where he was on his 29 April 1992 trip underground.¹⁶⁵ Salamon referred to the necessity for an inspector to be able to locate concerns accurately in order to evaluate, report, and compel correction:

Now, you know, a competent inspector would always make sure that he knows where he is. I mean, that's the number one requirement because if anything he observes, he must record I observed in such-and-such a place that this happened or didn't happen or shouldn't happen. . . . you don't go down to a mine as an inspector without making sure that you know where you are.¹⁶⁶

Finding

The inspectorate relied on Westray management for guidance and choice of inspection routes. Such reliance led to careless inspection and ignorance of the true state of operations underground at Westray.

The inspectors were unable to describe ventilation routes accurately, or detect ventilation concerns, especially during the 29 April inspection.

¹⁶⁴ Hearing transcript, vol. 76, pp. 16638–39.

¹⁶⁵ Hearing transcript, vol. 63, pp. 14009–14.

¹⁶⁶ Hearing transcript, vol. 15, pp. 2592–93.

White insisted on getting ventilation plans during the tunnel driveage, though the company was consistently late producing them. There was evidence that the inspectors were sometimes given copies of ventilation surveys, but no evidence of consistent and competent review of Westray's ventilation system.¹⁶⁷ In its final submission to the Inquiry, the Province of Nova Scotia stated that there was "no particular reason to be concerned about ventilation prior to the beginning of May [1992]."¹⁶⁸ This is not consistent with the facts described and analysed by expert witnesses elsewhere in this Report.¹⁶⁹

Inspectors did not routinely receive and review each other's reports, meeting minutes, or correspondence with the company.¹⁷⁰ McLean was not familiar with the terms and conditions of approvals for equipment, including the restrictions on use of mobile diesels.¹⁷¹ Inspectors looked only at a few of the most recent shift reports before travelling underground.¹⁷² A review of the 1992 shift reports would have revealed inadequate stonedusting. The shift reports completed by foremen were not as informative as they should have been. At least one foreman in his role as mine examiner understood that pre-shift reports included only those high gas readings taken late enough to indicate conditions for the start of the next shift. He did not record high readings at the Southwest 1 stoppings, since he did not feel it necessary to warn anyone about gas that was common knowledge.¹⁷³ As we have seen elsewhere, some foremen reported that they had been told by management not to put in information suggesting hazards, such as high gas readings, because the inspectors might look at the reports. Smith once questioned Phillips about Phillips's position that the mine was not gassy, after finding a reading of 0.8 per cent methane in the report book. Smith said Phillips's response was to ask: "Who told you that?"¹⁷⁴ Other reports, such as the daily overman's report required by section 37(4) of the *Coal Mines Regulation Act*, were not prepared at Westray; the inspectors apparently didn't notice. McLean showed new mine examiners at Westray how to take gas tests and how to fill out shift reports, but evidence suggests that poor reporting practices might have been related to management directives rather than deficiencies in training.

¹⁶⁷ McLean (Hearing transcript, vol. 56, pp. 12139–41).

¹⁶⁸ Department of Justice, Submission of the Province of Nova Scotia to the Westray Mine Public Inquiry, 9 August 1996, p. 6.

¹⁶⁹ See especially Chapter 7, Ventilation.

¹⁷⁰ Smith told the Inquiry that he "never saw any of the [other inspectors'] reports until after the disaster" (Hearing transcript, vol. 58, p. 12653).

¹⁷¹ McLean evidently didn't go out of his way to look for this sort of documentation: "If . . . it wasn't cc'd to me, I don't know about them" (Hearing transcript, vol. 55, p. 12024).

¹⁷² McLean claimed to have "always read reports . . . but I didn't read every one . . . I'd go back a few" (Hearing transcript, vol. 57, pp. 12490–91).

¹⁷³ Fraser Agnew (Hearing transcript, vol. 37, pp. 8079–88).

¹⁷⁴ Hearing transcript, vol. 59, p. 12948.

Records of Inspections

Reports and records were not circulated effectively within the department. The department's own records of dealings with Westray were sometimes altered.¹⁷⁵ White began editing the records of meetings with Westray about the time Phillips expressed concern about breach of Westray's business confidentiality in Department of Labour records. White denied any Westray management influence on the records, but Smith recalled being told that Phillips had expressed displeasure about the contents of the minutes of meetings.¹⁷⁶ White described his editing as an attempt to keep records of meetings limited to the issues directly concerning the Department of Labour and its actions.¹⁷⁷ The editing removed some references to potentially embarrassing matters. In one instance, references to extended deadlines for producing stonedusting and dust-sampling plans were changed. A remark, attributed to Don Jones of Natural Resources, to the effect that the government was under pressure to come up with acceptable answers to the problem or be forced to make unpopular decisions, was deleted from the record of a 15 October 1991 meeting.¹⁷⁸ White said he had the statement removed because "[i]t was not pertinent to what we in the department were trying to achieve."¹⁷⁹

Finding

Claude White's explanations for the altering of departmental records were not credible. The altering of official minutes made it more difficult to follow up on important safety matters that were central to the Department of Labour's mandate.

The Carl Guptill Saga

The events leading up to the dismissal of Carl Guptill are significant for reasons beyond the personal and direct hardship to the man himself. The story is a microcosm of employee/employer relations at Westray. It speaks to a broad range of recurring problems there – the lack of proper safety equipment for miners, the hazardous practices underground, the ineffectiveness of the mechanisms available to Westray miners with serious safety complaints, the attitude towards miners of Westray senior and middle management, and the absence of a safety mentality on the part of Westray management. The message this story conveyed to employees was clear: don't mess with management. The events also vividly point up the extent to which the provincial inspectorate was either apathetic to the conditions at Westray or so much in thrall to management at Westray.

¹⁷⁵ This came to light in part because Smith kept his rough drafts.

¹⁷⁶ Hearing transcript, vol. 59, p. 13012.

¹⁷⁷ Hearing transcript, vol. 64, pp. 14127–29.

¹⁷⁸ Exhibit 79.08.008, 012.

¹⁷⁹ Hearing transcript, vol. 64, pp. 14130–31.

Carl Guptill had no experience in underground coal mining when he came to Westray. He was a hard-rock miner, having worked as such for three years in two gold mines at Forest Hill in Guysborough County and for one year at the Gays River lead-zinc mine near Halifax. At Gays River, he was an underground foreman with 35 men on average under his supervision. From early on, Guptill had been interested in mine safety. At his first mining job, he was a member of the health and safety committee from its inception. He claimed to be familiar with the "Blue Book" – the *Occupational Health and Safety Act* – and he had attended a safety course at Dartmouth, which was arranged by his employer and the Department of Labour. He was very interested in mine rescue; he was captain of the A Team and was on the competition team. He said he probably had about 100 hours of training in mine rescue prior to joining Westray.

I was favourably impressed with Carl Guptill as a witness before this Inquiry. He seemed knowledgeable of, and concerned about, safety issues. He seemed the sort of person who wants to conduct himself pretty much "according to the book." Although some might label Guptill a chronic complainer, an overview of the miners' testimony does not support such a label. Throughout the testimony, there are many references to the numerous safety deficiencies to which Guptill drew attention. This fact adds credibility to Guptill's concerns and suggests he might better be labelled as vocal or concerned. In the explosion, his worst fears were realized.

While at the Forest Hill mine, Guptill was chairman of the health and safety committee, and in that capacity he developed a close working relationship with Albert McLean, the mine inspector. It had been Guptill's practice to accompany McLean on his inspection tours of the mine, without any management people in tow. Guptill would introduce McLean to the miners and then leave them to discuss their individual situations in private. McLean would discuss irregularities and ask Guptill whether or not he felt safe in the mine. Guptill said he "felt comfortable with Albert, we got along."¹⁸⁰ Guptill said that while he was at the Gays River mine there was a union attempt to organize the workers. At that time there was an increase in safety-related complaints, and McLean would arrive to check them out. When he hired on at Gays River, Guptill did not see much of McLean because he was not on the health and safety committee although, as a member of management, he would sit in on committee meetings with McLean.

Guptill was working at Gays River when the Westray mine opened. Shortly after, he was laid off along with a number of his co-workers, and he accompanied his friend Roy Feltmate to the Westray office and applied for a job. Although Feltmate was given a job almost immediately, Guptill was not called for some time. He met with Roger Parry, who said that he needed Guptill underground. Guptill said that he talked safety with Parry because "I wanted him to know where I was coming from . . . no one

¹⁸⁰ Hearing transcript, vol. 29, p. 6140.

should have to die underground.” Guptill said that he accepted the job at Westray after having stressed “my background in mine rescue and safety committees and all that.”¹⁸¹

Guptill’s one-day orientation at Westray consisted of a session with the training officer, William MacCulloch, who provided him with his various pieces of underground mining gear, including a self-rescuer with which he was already familiar. This was followed by the showing of two films and “pep talks” from Phillips, Parry, and Allen Karasiuk, the human resources officer. On the second day, the new employees went underground and spent the balance of the week setting steel arches. The next week, Guptill was assigned to work with B crew on the night shift under the supervision of Angus MacNeil. He worked a total of 13 shifts from 18 November to 8 December 1991, the date on which he was injured.

For the most part, Guptill assisted the roof bolters, stood arches, and at times ran the Scooptram. He never operated the continuous miner or the shuttle car. He described the conditions as gassy and dusty. The Scooptram raised so much dust that “you couldn’t see anything for dust.” At times he would see men “gassing out” – getting dizzy from methane – while working above the arches. Sometimes he would not go into those areas; he also refused to take a roof bolter out of an area that was about to collapse.¹⁸² This incident occurred almost at the face of the SW2-C1 Road (part of the area that was later abandoned because of roof conditions). He said he had lots of complaints but that MacNeil would respond by saying they had thousands of applications from guys ready to replace Guptill.¹⁸³ Indeed, it seems as though Guptill’s experience, as related by him, provides an overview of the Westray working environment. At one point, MacNeil told him to get rid of his safety glasses, since there was no room for people worried about safety on his crew.¹⁸⁴

Carl Guptill’s accident took place on 8 December 1991, and it triggered the series of events that eventually led to his dismissal from Westray. During the course of his shift, Guptill was assigned to unload steel arches in No. 1 Main. He was ordered to do this job in spite of the fact that his miner’s cap lamp was too dim. The only light he had at this time was from the lamps of the other miners in the vicinity. He was dragging a steel arch from a shuttle car when he tripped over a steel plate

¹⁸¹ Hearing transcript, vol. 29, pp. 6158–60.

¹⁸² Hearing transcript, vol. 29, pp. 6167–72. Guptill’s testimony outlines a veritable litany of safety complaints besides working in dusty, gassy conditions: working from the nose cone of the Roadheader (p. 6178); working from the bucket of the scoop with the machine unattended (p. 6174); working under an unprotected roof (p. 6172); and working without adequate ventilation (p. 6210).

¹⁸³ It would appear from some of the evidence that Angus MacNeil was a careless risk-taker. This impression may be due, in part at least, to the fact that MacNeil was a hard-rock miner with little training in coal mining. MacNeil’s employment records at Westray seem to bear this out. From the evidence of Bob Burchell (Hearing transcript, vol. 44, p. 9643), Doug MacLeod (vol. 27, p. 5622), and Buddy Robinson (vol. 30, p. 6399), the consensus was that MacNeil didn’t have enough training in coal mining and should not have been supervisor. The complaint about poorly trained hard-rock miners is common throughout the evidence.

¹⁸⁴ Hearing transcript, vol. 29, p. 6209.

and the arch landed on top of him.¹⁸⁵ As he lay with the steel pinning him down, he heard MacNeil say, “this is World War 3 down here; there’s bound to be casualties.”¹⁸⁶ Guptill was transported out of the mine on a tractor, and after he cleaned up he was taken to the hospital by his girlfriend. He said the company had offered to provide a taxi for him. He spent two nights in the hospital and was discharged on the morning of 10 December.¹⁸⁷ He said that evidence of his injuries included two large (dinner-plate-size) bruises on his stomach and back. During the afternoon of 10 December, Guptill called Parry to report in; the conversation, according to Guptill, deteriorated into a shouting match and he hung up. Guptill then called Claude White, director of mine safety at Labour, and told him about some of his safety concerns.¹⁸⁸ White acknowledged this call and said, “He expressed some complaints to me and I think I jotted down some of those complaints in my notebook. I don’t know if I got the total essence of what Mr. Guptill was saying, but I had enough to cause me considerable concern.”¹⁸⁹

As a result of this conversation, White instructed Albert McLean and John Smith to investigate Guptill’s complaints. It is at this point that the evidence and the recollections of the various inspectors become murky. A meeting was arranged for 16 December at the inspectors’ office in Stellarton. McLean and Smith attended for Labour; Fred Doucette was also in the office at the time but took no part in the meeting. It is clear that the Guptill complaint was raised with Westray management before 16 December. Smith’s monthly report noted that during the 12 December meeting there were “[a]lleged safety violations discussed with senior management.”¹⁹⁰ Smith said in evidence that he was pretty sure that Guptill’s name was mentioned.¹⁹¹

At the 16 December meeting, McLean took a statement from Guptill that related only to the accident and his injuries. McLean said that this statement covered all the topics addressed at that meeting. He was adamant that nothing was discussed at the meeting that did not appear in the accident statement taken from Guptill at that time. In response to a question at the hearing, McLean said: “That’s all he addressed to me at that time. He read that statement and signed it. . . . he had all the time in the world. He could have been still there writing if he wanted.”¹⁹² This evidence of McLean about what was discussed at that meeting is in stark

¹⁸⁵ Hearing transcript, vol. 29, pp. 6184–90. Guptill had loaned his lamp to Wayne Conway, whose lamp had gone dim and who needed light more than Guptill for the work he was doing. At this time (prior to being ordered to unload the steel arches), Guptill was passing supplies to the bolter crew.

¹⁸⁶ Hearing transcript, vol. 29, p. 6191. In his statement to the company dated 31 December 1991, MacNeil said: “I do not remember any WW 3 comments.” Doug MacLeod, who said he was around until Carl left, did not recall any such statements.

¹⁸⁷ Hearing transcript, vol. 29, pp. 6192–96.

¹⁸⁸ Hearing transcript, vol. 29, pp. 6197–99.

¹⁸⁹ Hearing transcript, vol. 64, p. 14081.

¹⁹⁰ Exhibit 139.11.018.

¹⁹¹ Hearing transcript, vol. 60, p. 13128.

¹⁹² Hearing transcript, vol. 57, p. 12601.

contrast to the version offered by Guptill. Guptill said that he went to the meeting with notes respecting his accident and injuries and a second set of notes listing various safety concerns. He said that McLean made photocopies of the notes respecting the safety concerns and said, “Now we’ve got someone that will actually sign a complaint. We can do something about the place.”¹⁹³ Although Smith’s evidence is difficult to follow on this point, it seems he also heard McLean say something to this effect.¹⁹⁴

I have no doubt that Carl Guptill not only discussed his accident and injuries at the 16 December meeting, but also raised and discussed a variety of other safety-related issues, which he had noted prior to the meeting. I am satisfied that Guptill brought to that meeting not only his notes relating to the accident but also several pages of notes relating to the other safety matters. During testimony, Guptill expanded on his notes.¹⁹⁵ Another twist to this story is the fact that Smith wrote out a copy of Guptill’s notes respecting the events leading up to and following the 8 December accident. Smith identified the notes in Exhibit 75.10.16–18 as being in his handwriting.¹⁹⁶ Smith said he had no recollection of when or under what circumstances this handwritten copy was made.

What transpired after the 16 December meeting reflects poorly on both the Department of Labour regulators and the company. It seems that once the Guptill complaint reached the ears of Westray management his future was decided. On 17 December, McLean and Smith went to Westray allegedly to investigate the Guptill accident complaint, although Smith’s monthly activity report showed that the visit was a previously scheduled meeting between the inspectorate and management. During a discussion of the Guptill accident, Smith heard Gerald Phillips refer to Guptill as a “g-d malingerer,” at which time McLean defended Guptill, saying he was not that type at all.¹⁹⁷ During this visit, Smith learned for the first time that Westray was working 12-hour shifts in violation of section 128 of the *Coal Mines Regulation Act*, which led him to ponder the problem of dimming cap lamps.¹⁹⁸

Smith reported the meeting to Claude White in writing on 27 December, and White directed him to remove any reference to the Guptill incident. The reasons for this instruction, according to White, were to avoid any possible breach of confidentiality and to protect any

¹⁹³ Hearing transcript, vol. 29, p. 6215.

¹⁹⁴ Hearing transcript, vol. 59, p. 12864. A reasonable conclusion to draw from this is that McLean and Smith expressed some satisfaction that they now had complaints upon which to act. When Inquiry counsel asked Smith: “And did you think that maybe Mr. Guptill was now going to give you the opportunity to do some sort of an investigation or to determine just what safety . . . practices were like?” Smith replied, “Yes, that’s reasonable. Yes, I can go with that (p. 12865).”

¹⁹⁵ Hearing transcript, vol. 29, pp. 6207–14. Guptill confirmed that the notes in Exhibit 75.10.20–21 were copies of the ones he took to the meeting.

¹⁹⁶ Hearing transcript, vol. 59, pp. 12850–51.

¹⁹⁷ Hearing transcript, vol. 59, p. 12867.

¹⁹⁸ The relationship between long shifts and dimming cap lamps, as well as the inspectorate’s reaction to it, is discussed in detail in Chapter 5, *Working Underground*.

disclosures that might arise from applications under the *Freedom of Information Act*. He further suggested that the deletion was ordered because the Guptill issue was not “germane” to that meeting, but he could not explain why he had deleted all reference to the incident.¹⁹⁹ I fail to understand the significance of either of these two excuses. I am not aware that the bureaucracy can use the *Freedom of Information Act* as a reason to sanitize documents, nor can I appreciate the reasoning behind the deletion based on its relevance to the matters discussed.²⁰⁰ I suspect that it was just another example of the regulators wishing to avoid any confrontation with Westray management or embarrassing publicity.

Guptill returned to light above-ground duties at the mine on 22 December and remained there until 22 January 1992, when he left the employ of Westray. His back had not improved, and Parry was challenging him to return to underground work. Finally, on 22 January, Guptill had a confrontation with both Parry and Phillips. According to Guptill, Parry suggested that he was a liability to the company and that it had been a mistake to hire him. Phillips indicated that the problem “about me [Guptill]” would be cleared, since Phillips had spoken to Albert McLean. Phillips concluded by saying that Guptill should have been fired when he first refused work.²⁰¹ Guptill then left work. He telephoned White to check on the progress of the investigation of his original complaints and was told that, by neglecting to take his complaint to the safety committee first, he had not followed proper procedure.²⁰² Another meeting was arranged between Guptill and McLean, and it took place several days later.²⁰³ Guptill thought that this meeting would be at the Stellarton office, as was the first meeting, but McLean called and asked that they meet at the Heather Hotel in Stellarton. According to McLean, this meeting was in preparation for another meeting to be held at the Westray offices, presumably with the safety committee. Again, the two versions of this meeting vary widely. Guptill said McLean suspected that Guptill was being “put up to this” by the United Mine Workers Union, which was involved in a certification campaign at the time. This is apparently why McLean had the television sound turned up, since he feared the conversation might be recorded.²⁰⁴ Guptill thought that a meeting with the safety committee would be a waste of time, since in his view there was no

¹⁹⁹ Hearing transcript, vol. 64, pp. 14132–33. White’s evidence on this point and his following comments (pp. 14194–200) are almost totally evasive. (Smith’s original notes are in Exhibit 139.01.88, 89f–89g.)

²⁰⁰ As suggested during White’s testimony, any confidentiality concern could readily be resolved by deleting the name of the complainant but leaving the other details intact.

²⁰¹ Hearing transcript, vol. 29, pp. 6220–23.

²⁰² Hearing transcript, vol. 29, p. 6224. According to the record, this is the first time that White, McLean, or Smith had mentioned anything about any requirement to report matters first to the safety committee.

²⁰³ This meeting took place while Guptill was still in the employ of the company.

²⁰⁴ This had been Guptill’s experience at the Forest Hill mine, and he felt that McLean may have thought this incident was merely a repeat of that organizing technique. “Creating the whole thing and stirring up trouble. That I had told him in Forest Hill was what I felt the crew was doing there when they started complaining about safety” (Hearing transcript, vol. 29, pp. 6230–32).

effective committee in place. McLean suggested that Guptill apologize to Phillips and Parry – and that by doing so he might be able to salvage his job. Guptill refused. Nothing came of this meeting, and Guptill maintained his refusal to meet with the safety committee.²⁰⁵

Sometime in late December, McLean had gone into the mine, in the company of Roger Parry, to get statements from Guptill's co-workers respecting the incident of 8 December. McLean maintained that Parry left him during the interviews, but Guptill said his friend Roy Feltmate told him that in Parry's presence the miners dared not speak freely.²⁰⁶ From all the other anecdotal evidence respecting mine inspections, it would appear inconsistent with practice for Parry to leave McLean alone underground. McLean maintained that he spoke privately with the men for about 25 minutes, that he spoke of nothing but the actual incident, and that he did not take any notes.²⁰⁷ I find it quite startling that the inspector, in the course of an accident investigation, would not record his findings. Indeed, as matters transpired, the only written statements from any of the miners were taken by the company and passed to McLean, who included them in one of his reports to White.

In all, McLean prepared and submitted three reports to White. Two of these were dated 7 February 1992 and the third (with the typed statements attached) was dated 13 March.²⁰⁸ It appears that McLean relied on the typed statements prepared by the company to make his findings. One statement purporting to be that of Carl Guptill was unsigned and contradicts at several points Guptill's handwritten notes. For instance, the typed statement said, "My light went dim while working on the bolter,"²⁰⁹ whereas the handwritten notes indicate what actually took place: "Wayne's [Conway] light went dim and he asked me for my light as he was drilling."²¹⁰ Listed under "Complaints" on the 13 March statement is, "He [Guptill] was made to work with a dim light." Under "Findings of Investigation" in the same report, McLean concluded, "Carl changed lights with Wayne Conway. It appears that Carl's original light did not go dim." (This is a repeat of a conclusion contained in one of the 7 February statements.) The undisputed fact is that, after Guptill changed cap lamps with Conway, he was directed to work with the dim lamp. Guptill blames the fact that he couldn't see what was on the roadway for his accident.

There is no credible evidence before me from which I could infer that Albert McLean conducted a thorough and independent investigation of the complaints of Carl Guptill, in relation either to the accident or to the other matters raised by Guptill at the 16 December meeting. Guptill had reason

²⁰⁵ Hearing transcript, vol. 29, pp. 6232–34.

²⁰⁶ Hearing transcript, vol. 29, pp. 6216–17.

²⁰⁷ Hearing transcript, vol. 56, pp. 12283–304.

²⁰⁸ Exhibit 75.10.003. One wonders why an experienced mine inspector, who had undoubtedly investigated many industrial accidents, would have to prepare and submit three simple accident reports before his supervisor deemed one to be acceptable.

²⁰⁹ Exhibit 75.10.005.

²¹⁰ Exhibit 75.10.020.

to believe, from his past experience with McLean at other mines, that he would conduct such an investigation. Instead, McLean ignored the general safety concerns expressed by Guptill, investigated the injury complaint in a cursory fashion, and filed a series of reports that were at best inconclusive. McLean ended each of these reports with the comment, “I find no flagrant violation of regulations in this case.” When asked by counsel why he used the term “flagrant,” McLean responded, “I don’t even know what that word means.”²¹¹ In the face of such cynicism (or perhaps buffoonery), I find it very difficult to accept as credible much of McLean’s evidence, especially where it conflicts with the evidence of Guptill and others.

From the very first contact Guptill had with the inspectorate, in the person of Claude White, the Department of Labour had some credible basis upon which to investigate allegations of unsafe underground practices. White acknowledged this by instructing McLean and Smith to conduct an investigation. A prudent and conscientious inspector would have gone to the mine, unannounced, and determined personally whether there was any substance to the complaints. This would be especially true of complaints filed by persons such as Carl Guptill, who was regarded by McLean as an honest and concerned employee. It was certainly not Guptill’s responsibility to establish and confirm each and every facet of the complaint – that, in my view, is the job of the inspector. And that is what McLean was doing in other mining environments, according to Guptill.

Finding

The inspectorate’s actions in the Carl Guptill incident were a disservice to a miner with a legitimate complaint, and a clear message to other members of the Westray workforce that the inspectorate was not going to support them in any safety-related confrontation with the management. The significance of this incident ought not to be understated. It is clear: (1) that the Department of Labour did not investigate all the complaints raised by Guptill; (2) that department officials, in the cursory investigation conducted, relied on statements prepared by the company without sufficient verification; (3) that department officials revealed the name of the complainant to the company; and (4) that references to the complaint were removed from meeting minutes in an apparent effort to avoid confrontation with the company.

That this message got through to, and was heeded by, the workforce becomes clear in the evidence of the miners and other underground workers at Westray.

²¹¹ Hearing transcript, vol. 56, p. 12298.

Extent of the Department's Responsibility

The Department of Labour was responsible for the application of the *Coal Mines Regulation Act* and the *Occupational Health and Safety Act* at Westray and for ensuring the health and safety of underground workers. Chapters earlier in this Report on training, working underground at Westray, ventilation, methane, dust, and ground control have documented in detail the violations that occurred at Westray, as well as the laxity of the inspectorate. The fact that the inspectorate understood the important safety issues in an underground coal mine has been documented; also documented is the fact that the inspectorate tolerated hazardous conditions and illegal practices underground, apparently because of its unwillingness to confront Westray management. I shall simply summarize in this section what the evidence has shown with respect to certain key issues: training and certification, equipment approvals, ground control, and dust sampling and stonedusting. But I wish first to comment generally on the significance of the inspectorate's attitude for the safety mentality.

Unsafe practices allowed or overlooked by the inspectors had a negative effect on the safety mentality at Westray. Salamon described the impact that regulatory authority has in this respect:

[I]t's a very disappointing thing to see if you see an inspector . . . do something which is wrong, unsafe or bad practice. The inspector always should . . . be a good example. Also, I think an inspector must observe when somebody else does something which is bad practice or unsafe practice and do something about it. In other words, he mustn't overlook without some reaction.

Now these . . . might appear to be small things, but psychologically, it's important.²¹²

Testimony from the underground workers confirms the negative effect that the inspectors' attitude had.

Miners expected the inspectors to be sufficiently competent to recognize areas of concern, and assumed the inspectors knew what was bad practice in the mine. Knowledgeable miners thought that the mine inspectors either were under pressure to avoid sanctions against the company or just chose not to take the miners' concerns seriously.²¹³ Some experienced coal miners knew how the provincial inspectorate had operated at other mines. Others knew what to expect from mine inspectors in other jurisdictions. The new miners had no experience upon which to base comparisons. Westray workers who knew something of mine safety were disillusioned when inspections did not result in corrective measures. Other workers took the lack of effective regulatory response as approval of practices in the mine.²¹⁴

²¹² Hearing transcript, vol. 14, pp. 2453–54.

²¹³ Buddy Robinson was in the former category. When McLean told Robinson that his hands were tied, Robinson assumed "that his superiors were telling him to lay off [Westray]" (Hearing transcript, vol. 30, pp. 6347–48).

²¹⁴ These points are well illustrated with references in Chapters 7, 8, and 9, Ventilation, Methane, and Dust.

The pattern of laxity appears in Labour's handling of the training and certification of underground workers at Westray. Chapter 4, Training at Westray, describes the training program as presented to the department and as implemented. Despite recurring feedback from Westray's workers, the regulators never insisted on proof of implementation of an adequate training program. The inspectors merely kept putting the matter on the agenda at meetings with company officials.

Labour's handling of the approvals process for equipment used underground at Westray illustrates a similar pattern of deference to the company. Section 85(2), rule 4, of the *Coal Mines Regulation Act* allows the electrical inspector to give permission on written request for the use of equipment "not of a type or kind that has been approved as permissible equipment in the intake airways or in a place ventilated by a split of fresh air." Both Smith and White spent considerable time and energy drafting conditions in response to the company's purchase and use of underground equipment not covered by existing regulations.²¹⁵ Post-explosion analysis of the equipment documentation revealed problems of misidentification, wrong certification information, and unapproved equipment used in the mine.²¹⁶ Chapter 5, Working Underground at Westray, documents how conditions for use of equipment were ignored. The inspectorate relied on the company's voluntary enforcement of the conditions and the company's code of practice for that use. White assumed that the company would manage the matter effectively. He accepted Phillips's assurances that equipment would be used properly, that workers would be informed about the conditions, that supervisors would insist on strict adherence to the rules, and that signs would be posted at the limit of permitted use.²¹⁷ Testimony from the miners flatly contradicts White's assumptions.

Finding

Claude White is a professional and experienced mining engineer. His job was to see that the mine inspectorate enforced the *Coal Mines Regulation Act* and the *Occupational Health and Safety Act*. He failed to do so.

Smith's site visit reports indicate that he examined and found deficiencies in equipment. He seemed particularly interested in keeping the non-flameproof equipment out of the "hazardous zone." He once paced off the 300-foot distance from the face as a demonstration for Bob Parry. He said he was sceptical about the enforcement of restrictions on vehicles.²¹⁸

²¹⁵ Smith (Hearing transcript, vol. 58, pp. 12688–89).

²¹⁶ John Bossert testimony (Hearing transcript, vol. 12, pp. 2092–2150).

²¹⁷ "[W]e had no reason to suspect that the mine was not properly managed" (Hearing transcript, vol. 63, pp. 13856–70).

²¹⁸ Hearing transcript, vol. 59, pp. 12912–33. **Comment** Scepticism seems to be a necessary quality for any person whose job it is to inquire into compliance with standards, rules, or regulations. It is painfully evident that a healthy scepticism was missing from the Department of Labour inspectorate, in favour of misplaced trust, apathy, and deference to Westray management.

McLean considered equipment issues to be someone else's concern. He once gave Roger Parry permission to use a non-permissible shotcrete machine underground but stated that approvals, even respecting placement of auxiliary fans, were not his responsibility. He said he knew of the conditions for approval of underground equipment, but only from discussions at meetings.²¹⁹ White was disturbed at McLean's claim not to have seen the conditions, since copies had been sent to his office.²²⁰ McLean's lack of understanding of ventilation routes during the latter days of the mine's operation suggests that he could not have detected unacceptable use of tractors, since he did not always know when he was in return air. There were reports of McLean riding a tractor in an area of the mine where its use was prohibited.²²¹ McLean did not enforce compliance with conditions on mobile equipment.

The inspectors did not ask the miners what they knew or did about restrictions on equipment. Smith noted on a September 1991 inspection report that management did not post notices as required.²²² McLean made no meaningful response to reports of tractor travel beyond approved areas. Specific complaints were made to him by members of the Westray safety committee early in 1992. He merely wrote a memo to White, including reference to how he had informed the committee that the department had approved the use of the tractors except in return air or past the last open cross-cut.²²³ He never replied to the committee, or sent them copies of his report.

Finding

The inspectors' handling of the equipment permits was inadequate. They made errors in paperwork and communicated poorly among themselves. They permitted Westray management to intimidate them and ignored the concerns of the miners and the input of the safety committee. They left the enforcement of the conditions for equipment use with Westray officials.

The interactions between the inspectorate and Westray management on the issue of ground control followed a similar pattern. The inspectorate recognized a concern, and management attempted to downplay it.

Roof problems appeared early in the life of the mine. By February 1991, McLean was concerned about roof conditions. By May, Noonan requested a roof-fall report to brief the minister and deputy.²²⁴ In July 1991, Phillips was reminded that if a "refusal" occurred because of increasingly serious roof problems, the department "would have no

²¹⁹ Hearing transcript, vol. 56, pp. 12142–51.

²²⁰ Hearing transcript, vol. 63, pp. 13857–58.

²²¹ Ed Estabrooks (Hearing transcript, vol. 24, pp. 4891–92).

²²² Exhibit 139.03.05.

²²³ Exhibit 120.306.

²²⁴ Hearing transcript, vol. 69, p. 15124.

alternative but to get involved.”²²⁵ The roof problems called for an increasing amount of attention by the company and the department, and are addressed fully in Chapter 10, Ground Control. There is some indication that the company was minimizing the extent of the problem. Labour accepted management descriptions of controlled falls and test areas despite McLean’s protests that it was not possible to predict the timing of roof falls in that manner.²²⁶ McLean, to his credit, recognized the complexity and severity of the roof problems in the mine from an early point. He urged the department to hire an independent consultant to monitor roof problems at the mine and assess the company’s response. Labour did not follow McLean’s suggestion and occasionally borrowed an engineer from Mines and Energy to attend meetings with the company.²²⁷ Labour directed the company to address roof problems, which the company was already trying to resolve.²²⁸ According to Kevin Gillis, the inspectors knew that people had quit their jobs because of dangerous conditions.²²⁹ They did not confront the risk to the remaining workers under these conditions, beyond discussions in meetings and warning a few people not to work under bad roof.

When Southwest 1 was abandoned in March 1992, Parry called McLean to let him know only after workers and equipment had been pulled from the area. McLean looked at the area of the falls on 31 March but could not later describe their location or the extent of the area affected. He accepted the assurances of management that the retreat had taken place in orderly fashion, that waves of gas coming out of the old workings were being monitored, that proper substantial stoppings would be built later when the whole of the Southwest section was completed. No one at Labour seems to have had any appreciation of the risks borne by the miners during and after the development in the Southwest 1 area. Salamon said, “[P]eople don’t appreciate this could have fallen, completely fallen in 20 seconds. Nobody would have come out of it alive.”²³⁰

It has been suggested that the attention paid to the roof problems distracted the inspectorate as well as the company from other serious

²²⁵ Exhibit 139.01.41. Smith, who wrote this memo to White, agreed in testimony that “refusal” most likely referred to a potential refusal of Westray employees to work in what they might consider dangerous conditions (Hearing transcript, vol. 59, p. 13004).

²²⁶ Hearing transcript, vol. 56, pp. 12213–14. McLean thought it was just luck that no one had been injured in roof falls (pp. 12159–60). In fact, as we know, some miners *were* hurt by falls.

²²⁷ McLean described the 15 October 1991 meeting as the first time the mine inspectors got together to work with the Mines and Energy engineers after the transfer of the unit created a communications gap between the groups (Hearing transcript, vol. 55, pp. 11942–43).

²²⁸ White wrote on 22 October 1991 asking for a progress report, and Phillips responded a month later with a careful letter asking for more time to respond (Exhibit 139.01.78). The company deferred the need to respond to the 4 November 1991 orders by simply not accepting the registered letter.

²²⁹ Hearing transcript, vol. 47, pp. 10158–59.

²³⁰ Hearing transcript vol. 15, p. 2778. Salamon thought that there should have been regulatory review of the situation when the Southwest 1 panel failed after radical change in the mining method used. The dire need for good ventilation engineering and practices to deal with problems likely to arise from the abandoned workings apparently went unconsidered, or was left completely in the hands of the company. The inspectors simply did not appreciate and act on the implications of the Southwest 1 area.

safety hazards. The department's response to the roof problems is consistent with its pattern of reliance on the company and acceptance of company undertakings. It is conjecture to suggest that the inspectors might have looked after other concerns any better in the absence of roof problems.

Westray's dust control practices did not conform with the normal standards in a coal mine. Nevertheless, the department relied on the company's promises to comply with regulations and with departmental requests for stonedusting and dust-sampling programs. Phillips's plan for the treatment and testing of the dust, in the Manager's Safe Working Procedures, did not provide a sufficient basis for assessing the procedures.²³¹ Chapter 9, Dust, addresses these problems.

The state of the stonedusting was frequently mentioned in the inspectors' reports, with occasional references by McLean to stonedusting being good, but more frequent mention of the need for better dust control. The inspectorate relied on visual inspection to confirm acceptable levels of stonedust. White claimed an experienced miner could accurately assess an 85 per cent non-combustible content.²³² He said that sampling was no substitute for visual inspection, chiefly because of the delay in getting sampling results. But in spite of this belief he pressed the company for stonedusting and dust-sampling schemes from mid-1991.²³³ McLean knew that lab tests were necessary to confirm the content of the dust in the mine, though visual inspection allows one to spot obvious differences in dust colour.²³⁴ It had been the practice of the department to sample dust at the small coal mines, and McLean had done so. He volunteered to take dust samples at Westray when the company reported it lacked the necessary equipment, but White told McLean that it was not his job to take dust samples.²³⁵ This direction had come down from Jack Noonan. White agreed it was not appropriate for the inspectors to provide sampling services at Westray.²³⁶ Noonan said that McLean could have taken samples to audit for compliance only if he suspected non-compliance, not because the company was not prepared to do it.²³⁷ That is *not* what the inspectors understood.

Table 9.2 (References to Dust by Inspectors, pages 337–39) and the accompanying text in Chapter 9 tell a story of inadequate stonedusting,

²³¹ Trevor Eagles (Hearing transcript, vol. 76, pp. 16578–79).

²³² Hearing transcript, vol. 63, pp. 13861–63.

²³³ See, for example, the report of a meeting with Westray on 17 December 1991 (Exhibit 139.01.85).

²³⁴ Supervisors in the mine claimed that only the laboratory confirmation of dangerous levels of combustibility could have been used to convince senior management of the need to deal with the dust properly.

²³⁵ Hearing transcript, vol. 57, pp. 12454–57.

²³⁶ White felt that "what we were trying to do is get the company to establish their program and I did not want to give the company the impression that we would undertake that sampling program on their behalf." He went on to say that "[a]t no time did I suspect that we were not achieving the level of stone dusting that was required" (Hearing transcript, vol. 64, pp. 14034–38).

²³⁷ Hearing transcript, vol. 69, pp. 15103–07.

broken promises, and ineffective regulation at Westray. The saga that began with a report by McLean on 8 May 1991 that “stonedust has been ordered,”²³⁸ was still playing out by the end of April 1992. Geologist Kevin Gillis told McLean about coal dust accumulations he had observed in the mine during a trip underground in April 1992. McLean’s response was: “‘Yes, we’re trying to get the company to . . . give us their plan.’”²³⁹

29 April 1992 Inspection

On 29 April 1992, White, McLean, and Doucette travelled to the Westray mine for an inspection. Doucette was concerned about rumours of water seeping into the Southwest section, possibly from the flooded Allan mine.²⁴⁰ In a statement to the RCMP on 28 July 1992, White explained why he went underground that day: “I had an uneasy feeling about the stonedusting . . . It was the stonedusting scheme I was concerned with.”²⁴¹ McLean was there for his routine inspection.

The inspectors checked the plywood and plastic barriers in the Southwest section. Only Doucette saw anything wrong, but he accepted Parry’s explanation that the structures were temporary barricades to keep workers out.²⁴² The so-called stoppings were not built to the standards required for sealing off old workings and had buckled by the end of April, a few weeks after they were built. The intake air for the Southwest 2 section was flowing past the abandoned section, in contravention of section 71(6) of the *Coal Mines Regulation Act*. The inspectors saw nothing wrong in the ventilation of the mine on that date. Trevor Eagles’s surveys showed high gas readings and buckling of the stoppings before and on 29 April. The inspectors did observe coal dust conditions in the mine that resulted in orders to clean up and treat the dust, and to produce the dusting and sampling plans that had been promised in September 1991. These orders are set out in full in table 9.2 on page 339.

McLean told the Inquiry that he gave oral orders to Parry and Phillips, and provided a written copy to the mine on 30 April. According to McLean, Phillips was present, although it was Parry who signed the written order. Copies were made, and one was posted for the employees’ information.²⁴³

²³⁸ Exhibit 139.01.27.

²³⁹ Hearing transcript, vol. 46, pp. 10118–19.

²⁴⁰ Hearing transcript, vol. 60, pp. 13262–63. Gillis had passed on his own suspicions to Doucette (vol. 46, pp. 10119–20).

²⁴¹ Exhibit 126.3(A), p. 2.

²⁴² Hearing transcript, vol. 60, pp. 13286–88. Doucette did not consider either of these structures to be a stopping, which he defined as “a permanent structure to prevent not only access but any outlet or egress of any type of gas that may be contained within it.” Ventilation experts McPherson and Mitchell made similar observations to the Inquiry.

²⁴³ Hearing transcript, vol. 57, pp. 12437–43. McLean was at the mine site on 6 May but did not check on progress towards compliance. He was awaiting written notification of compliance from Westray (vol. 60, pp. 12444–46). Department of Natural Resources engineer John Campbell met him in the parking lot at Westray that day and mentioned dust accumulations Campbell had observed in the mine between No. 10 and No. 11 Cross-cuts on 1 May. McLean did nothing in response to Campbell’s comment, despite the 29 April order for “immediate” action (vol. 47, pp. 10286–88).

McPherson said that it would have been prudent for the inspectors to take stronger action earlier respecting the combustible dust problem: “The matter of coal dust and the lack of stonedusting during the physical inspections of the mine by the inspectorate . . . must have been visually obvious to them.”²⁴⁴ McLean said that the many recorded references to the need for better dust treatment reflected routine reminders to work towards the goal of a white mine.²⁴⁵

Given the past performance by Westray management, it would have been prudent for the inspectors to check on compliance. White said that the company had always complied with previous requests. He saw no reason to suspect the work would not be done within the time ordered. He told the Inquiry at one point that the inspectorate assumed it was dealing with a responsible operator that “showed a high degree of concern for safety.”²⁴⁶ White admitted that he considered the prospect of shutting the mine down for non-compliance with the orders.²⁴⁷ I must note that any evidence that Westray had a “high degree of concern for safety” did not come to light during the public hearings of this Inquiry. To the contrary, the Inquiry record is replete with examples of cynical disdain for safety concerns, ignored undertakings respecting safety improvements, and continuing violation of the most basic safety rules.

Trevor Eagles took two dust samples on 29 April. The results, reported on 7 May, showed combustible matter to be well in excess of the permissible levels. Steven Cyr was one of the miners riding into the mine with Eagles on the morning of 8 May 1992. When the discussion turned to whether workers in the North mains section could survive a methane explosion in the Southwest section, Eagles apparently commented that it was unlikely, “‘not with the amount of coal dust that we’ve got in this pit.’”²⁴⁸

Sadly, the follow-up to the orders of 29 April was consistent with the continuing relationship between the inspectorate and Westray management – the inspectorate assumed work would be completed and relied on the undertakings of management. Time and again, the inspectorate chose to leave remedial matters to management. In the case of the 29 April orders, the company was simply ordered to remedy several dangerous conditions existing in the mine. The inspectorate made no effort to ensure compliance, even though McLean returned to the mine site several days later.

The Department of Labour in general, and the inspectorate in particular, was markedly derelict in meeting its statutory responsibilities at the Westray mine. This company demonstrated a disdain for any regulatory regime, whether the regime concerned the safe design of the

²⁴⁴ Hearing transcript, vol. 9, p. 1709.

²⁴⁵ “I’m always after stonedust; that’s part of my job to go in and try to get the mine white” (Hearing transcript, vol. 57, pp. 12554–55).

²⁴⁶ Hearing transcript, vol. 63, p. 13767.

²⁴⁷ Hearing transcript, vol. 63, p. 13885. He had also discussed this with Smith.

²⁴⁸ Hearing transcript, vol. 25, pp. 5150–51.

mine or the safe operation of that mine. The inspectorate had its own duties to carry out, as enumerated in the legislation, and it failed to do so. It must be profoundly unsettling to the people of Nova Scotia to realize that the safety inspectorate is so demonstrably apathetic and incompetent.

Finding

The Department of Labour was ill prepared for the task of regulating Westray. The inspectorate was untrained, poorly supervised, and improperly motivated. No efforts were made, through either training or motivation, to develop a competent inspectorate capable of monitoring a safety program at Westray. Even those sections of the *Coal Mines Regulation Act* that could have been of benefit to the Westray worker were largely ignored. By and large, through incompetence and apathy, the inspectorate of the Department of Labour did a disservice to the Westray miners and the people of Nova Scotia.

Specifics of the inspectorate's shortcomings are set out elsewhere in this Report.

RECOMMENDATIONS

- 55 The unacceptable performance of Claude White and Albert McLean in the conduct of their duties as mine-safety inspectors and regulators, coupled with their demeanour at the Inquiry hearings, must surely have destroyed any confidence the people of Nova Scotia might have had in the department's safety inspectorate. Accordingly, both White and McLean should be removed from any function relating to safety inspection or regulation.
- 56 The lassitude that paralysed the inspectorate and rendered it ineffectual in dealing with Westray seems deep-seated and pervasive. Therefore, an independent and professional safety consultant should evaluate the inspectorate and its personnel. The consultant should make recommendations for the restructuring of the safety inspectorate and its staff to ensure that the workers and the people of Nova Scotia benefit from a competent, well-trained, and properly motivated safety inspectorate.

Occupational Health and Safety Act, 1996

It seems fitting at this juncture to comment on the new *Occupational Health and Safety Act* of Nova Scotia, which was proclaimed law in the summer of 1996. By and large, this act – the product of years of dedicated research by a tripartite committee of labour, management, and government – does a reasonable job of legislating the safety and health of workers in this province.²⁴⁹ The act states at the outset: “The foundation of this Act is the Internal Responsibility System . . .” If, by this proclamation, the act

²⁴⁹ *Occupational Health and Safety Act*, SNS 1996, c. 7. The new act was written by the Occupational Health and Safety Council, co-chaired by Robert Wells and Robert McArel.

is intended to perpetuate the clear misunderstanding of IRS as articulated by Macdonald, Noonan, White, and McLean, then it appears that we are in for more of the same passive and non-interventionist regime that was in place at the time of Westray. If, in contrast, the new *Occupational Health and Safety Act* is a wake-up call to informed and dedicated training and the monitoring of safety concerns in the workplace combined with intelligent, objective, and aggressive enforcement by a responsible inspectorate, then the act may usher in a new era of worker safety and health. I have grave reservations about whether the present inspectorate is competent to discharge this responsibility, given its mind-set respecting IRS as articulated in the testimony and in the brief to this Inquiry. These reservations are reflected in the findings and recommendations of this Report.

Apart from these general observations, several specific portions of the new *Occupational Health and Safety Act* bear comment.

Role of the Supervisor

The Ham and Burkett reports, which set out the concept of IRS and upon which most subsequent mining-related occupational health and safety legislation in Ontario is based, are quite specific with respect to the duties and responsibilities of the supervisor. There is no section in the Nova Scotia act devoted to the duties and responsibilities of the supervisor; nor is the position set out in the opening section listing the participants in the IRS (section 2(a)). Nor is there any provision setting out the level of competence, training, or experience to be expected of a supervisor. Both Ham and Burkett placed considerable stress on the relationship between employee and supervisor as a major factor in achieving a sound and workable IRS. It may be of advantage to have the role of the supervisor set out and defined in the new act.

Outside Contractors

In many circumstances, there may be employees of more than one employer at any given worksite. The act defines the role of the contractors adequately (sections 14, 15), but the role of the employee with respect to the employees of another employer is not spelled out. Although the employee is required to cooperate with “fellow employees” for their mutual protection, there is no mention of extending that cooperation to others. There should be a provision for cooperation among all employees at the worksite. It would cover the situation where the employee of an outside contractor is performing hazardous work – welding, for example – and “employees” of the “employer” are present. This provision could be achieved by simply expanding the definition of “employee.”

Definition of Reportable Injuries

Provisions for reporting accidents are contained in sections 63 and 64 of the act. Accidents must be reported within seven days if they resulted in “bodily injury to an employee.” Unfortunately, “bodily injury” is not

defined, and this could lead to abuse; the system could become overwhelmed if every cut and scratch were construed as “bodily injury.” It would add more certainty to this section, and lessen the possibility for abuse, if bodily injury were defined (for the purposes of reporting) as an injury requiring medical attention or hospitalization or resulting in the inability of the employee to continue with normal assigned duties. The same comment applies to the phrase “serious injury” in reference to disturbance of the scene of an accident.

Joint Occupational Health and Safety Committee

The act quite properly places much of the general administration and promotion of the safety program with the joint occupational health and safety committee. Sections 29–32 establish the composition of the committee, the functions of which are detailed in section 31 as follows:

Functions of committees

- 31** It is the function of the committee to involve employers and employees together in occupational health and safety in the workplace and, without restricting the generality of the foregoing, includes:
- (a) the co-operative identification of hazards to health and safety and effective systems to respond to the hazards;
 - (b) the co-operative auditing of compliance with health and safety requirements in the workplace;
 - (c) receipt, investigation and prompt disposition of matters and complaints with respect to workplace health and safety;
 - (d) participation in inspections, inquiries and investigations concerning the occupational health and safety of the employees and, in particular, participation in an inspection . . . ;
 - (e) advising on individual protective devices, equipment and clothing that, complying with this Act and the regulations, are best adapted to the needs of the employees;
 - (f) advising the employer regarding a policy or program required pursuant to this Act or the regulations and making recommendations to the employer, the employees and any person for the improvement of the health and safety of persons at the workplace;
 - (g) maintaining records and minutes of committee meetings in a form and manner approved by the Director and providing an officer with a copy of these records or minutes on request; and
 - (h) performing any other duties assigned to it
 - (i) by the Director
 - (ii) by agreement between the employer and the employees or the union, or
 - (iii) as are established by the regulations.

It is vitally important that the committee not be diverted from its principal task of promoting and maintaining a safe workplace, be it an underground coal mine, a surface mine, or an industrial complex. I say this only to emphasize that, although the means may vary depending on the nature of the workplace, the objectives should always be the same. If one accepts this general proposition, it follows that the composition of the committee is of some importance. I am strongly of the view that the

membership of the committee should be removed, as much as possible, from day-to-day employee-employer relations. Health and safety should be the sole concern of the committee, to the exclusion of all other matters. Health and safety considerations should not play a role in union-management relations or be subject to the adversarial attitude that sometimes colours these relations.

My own observations of the conduct of some union officials at a mine site brought this whole question to my attention.²⁵⁰ My initial thoughts were reinforced by the commentary in part 5 of the Boyd report to Natural Resources Canada.²⁵¹ Similar concerns were expressed to me by others connected with the mining industry. Such concerns are not the result of isolated incidents, as is evident from the reservations expressed in *Towards Safe Production*:

It will not have escaped union attention that the two mines in the industry which consistently experience superior safety performance do not have union-represented employees. This fact strongly suggests that the adversarial climate which invariably accompanies most union-management relationships should be critically reassessed by unions when it comes to matters of health and safety.

...

The Ontario Mining Association and a number of the companies appearing before us suggested that the adversarial system of labour relations is hindering safety performance. The Ontario Mining Association, citing the Ham report which maintains that there is no place for the adversarial system in dealing with health and safety, suggested in its initial submission that this Commission could make its greatest contribution to the prevention of accidents by analysing the dynamics of adversarial relationships and their effects.

...

The answer to the difficulties created by the carryover of adversarial approaches into safety matters lies in the structures designed to promote improved safety performance and in the maturity of the parties themselves.²⁵²

Unless some effort is made to separate the promotion and administration of health and safety matters from the general concerns of the workplace, it could be almost impossible to deal with one aspect to the exclusion of the other. The danger is that, if any amount of intermingling takes place, health and safety concerns may be trivialized or even lost in the milieu of employee-employer relations. To avoid, or at least minimize, this possibility, committee membership should be restricted. Management appointees must be persons whose interest is the promotion of health and safety without any other management agenda. Employee representatives must have a similar disinterest in any other employee-union agenda.²⁵³

²⁵⁰ This incident is related in the section on mine visits in Chapter 16, *The Inquiry*.

²⁵¹ John T. Boyd Company, "Technical and Operational Assessment of Cape Breton Development Corporation," report to Natural Resources Canada (1996).

²⁵² Burkett Report, 84–86.

²⁵³ Such restrictions may not have practical application in smaller workplaces.

There seems to be a gap relating to representation of non-union workers on any joint occupational health and safety committee. There may be technical or other support staff who are non-union but who have a definite stake in workplace health and safety. The size of the committee is determined by agreement between "the employer and the employees or their union or unions" (section 30(1)). The employee members of the joint occupational health and safety committee are to be selected by "the employees they represent, or designated by the union that represents the employees." It may be prudent to revisit this section to clarify how the interests of non-union employees in an otherwise union shop will be covered.

Generally, the *Occupational Health and Safety Act* seems to do a good job of protecting the health and safety of workers. Any act is only as good as its administration and enforcement, and these aspects will be addressed elsewhere in this Report.

RECOMMENDATION

- 57 The *Occupational Health and Safety Act*, 1996, should be revised to incorporate the following changes:
- (a) Except in the case of a demonstrated emergency, any communication respecting health and safety concerns should go initially to the first-line supervisor. If the first-line supervisor is unable or unwilling to resolve the matter, then the complaint should be taken directly to a member of the joint occupational health and safety committee, for resolution by the committee as expeditiously as possible.
 - (b) Provisions should be adopted to clarify how interests of non-union employees in a union shop will be met on the joint occupational health and safety committee.
 - (c) No member of management whose principal duty or concern relates to production quotas should be eligible for membership on the joint occupational health and safety committee.
 - (d) No member of the executive of any employee organization or union, or any person who has served in such capacity within the preceding year, should be eligible for membership on the joint occupational health and safety committee.
 - (e) Provisions should be adopted to define clearly the health and safety obligations of employees to workers on site who are employed by contractors other than the principal employer. Those contractor employees should have obligations similar to those of the employees of the principal employer.
 - (f) For greater certainty, the terms "serious injury" and "bodily injury" should be replaced with the one term "serious injury," defined as any injury that requires immediate medical aid or hospitalization or renders the employee unable to perform his or her regular duties for a period in excess of 24 hours.
-