

CANADA / JUDGMENT

R. v. J. Cote and Son Excavating Ltd.

2025 BCSC 2540

COURT

Supreme Court of British Columbia

DECIDED

11 December 2025

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2025 BCSC 2540 R. v. J. Cote and Son Excavating Ltd.

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

R. v. J. Cote and Son Excavating Ltd.,

2025 BCSC 2540

Date: 20251211

Docket: 35002

Registry: Vancouver

Rex

v.

J. Cote and Son Excavating Ltd. and David John Green

Before: The Honourable Justice Brundrett

Oral Reasons for Judgment

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Place and Dates of Trial:

Vancouver, B.C.

January 20-24, 27-31

February 3-7, 10-13, 18-21

February 24-25, 27-28

March 3-6, 10-13

April 22-25, 28-30

May 1-2, 12

September 23-25, 2025

Place and Date of Judgment:

Vancouver, B.C.

December 11, 2025

Table of Contents

INTRODUCTION.. 4

CIRCUMSTANCES. 5

- 1) General Background. 5
- 2) The Background to the Sewer Replacement Project 6
- 3) Design of the Sewer Replacement Project 8
- 4) Craig Walden's Involvement 10
- 5) The Pre-Construction Meeting. 11
- 6) The Work Crews on the Edinburgh Site 12
- 7) The Area in and Around the Retaining Wall and Trench. 12
- 8) The Retaining Wall that Collapsed. 14
- 9) The Distance from the Trench to the Retaining Wall 16
- 10) Thomas Richer - Pipelayer for J. Cote, Injured in the Trench Collapse. 17
 - a) Credibility. 17

- b) Background. 18
- c) Mr. Richer's Evidence that he Warned Others. 19
- 11) The Collapse of the Retaining Wall 20
- 12) Certification of the Trench Work. 22
 - a) Mr. Yip's Background. 22
 - b) Mr. Yip's Understanding of His Role. 23
 - c) Mr. Yip's Attendance at the Edinburgh Laneway. 23
 - d) The Earthbitat Geotechnical Certificate. 25
 - e) Post-incident Involvement by Mr. Yip. 28
 - f) Professional Disciplinary Process re Mr. Yip. 29
- 13) Prior Unsafe Practices. 29
- 14) Whether Mr. Richer Raised Concerns with Others about the Safety of the trench. 29
- 15) Whether the Soil Conditions Changed. 29
- 16) WorkSafeBC Investigators. 30
 - a) Lonny Bouchard. 30
 - b) Mr. Fielding. 31
- 17) Mr. Weiss's Investigation. 32
- 18) Dr. Mehrdad Hamidi 35
- 19) Andrew Kidd, WorkSafeBC Expert 39
- 20) The Cause of Death of the Deceased, Mr. Jeffrey Caron. 41
- 21) The Defence Evidence. 42
 - a) The Accused, David Green. 42
 - b) Chad Allen. 44
 - c) Jamie Cote, the Principal of J. Cote. 45
- LEGAL PRINCIPLES. 48
 - 1) The Criminal Negligence-Based Offences (Counts 1 and 2) 48
 - a) A Legal Duty. 49
 - b) The Actus Reus and Causation. 49

- c) The Mens Rea - Marked and Substantial Departure. 50
- 2) The Unlawful Act Manslaughter Offence (Count 3) 51
- 3) Corporate Liability. 53
- 4) Legal Scheme Governing Excavation Work in B.C. 56
- a) The WCA. 57
- b) The Occupational Health and Safety Regulation ("OHSR") 60
- d) WorkSafeBC Guidelines. 63

IMPORTANT FACTUAL DISPUTES. 64

- 1) Safety practices. 64
 - a) Safety Manual 64
 - b) Safety Meetings. 66
 - c) Hazard identification. 67
 - d) Lack of Formal Training. 68
 - e) Conclusion with Respect to Safety Practices. 69
- 2) Reliance on the October 2 Certificate. 70
 - a) Application to Initial Position or Entire Trench. 70
 - b) Whether the Term "Loads" Captured Retaining Walls and Adjacent Structures. 73

ANALYSIS. 78

- 1) Criminal Negligence Offences. 78
 - a) Legal Duty. 78
 - b) The Actus Reus. 79
 - c) The Mens Rea - Marked and Substantial Departure. 80
 - i. Reasonable Foreseeability of Harm 81
 - ii. Marked and substantial departure. 83
- 2) Unlawful Act Manslaughter 90

CONCLUSION.. 92

INTRODUCTION

- [1] The following reasons address charges arising out of a tragic industrial incident that occurred on October 11, 2012, in Burnaby, B.C., that resulted in the death of one worker and injury to another.
- [2] The incident occurred on a residential laneway in north Burnaby, where a combined sewer and sanitation pipe was being replaced in a trench near a retaining wall. The wall, which was not reinforced, sloped, or anchored to the hillside, suddenly fell into the trench, striking two pipelayers. Mr. Green, the foreman on site, is charged with:
- 1) Criminal negligence causing death (under s. 220(b) of the Criminal Code, R.S.C. 1985, c. C-46 [Code]);
 - 2) Criminal negligence causing bodily harm (s. 221(a) of the Code); and
 - 3) Manslaughter (s. 236 of the Code).
- [3] J. Cote & Son Excavating Ltd. ("J. Cote"), the company Mr. Green worked for and the prime contractor for the sewer separation program, is charged on the first two counts.
- [4] The Crown called numerous witnesses during the 48-day trial, including eyewitnesses, neighbours, technical experts, and those responsible for the contracting and supervision of the project. The defence called Mr. Green, Mr. Allen (another foreman), and the president and owner of J. Cote, Jamie Cote.
- [5] There is little dispute that the trench collapse occurred, harm, including a death, resulted, and that better safety precautions should have been taken to prevent this tragic incident. I have little difficulty in finding that there was a failure to take appropriate action to prevent the collapse. However, assigning blame in the criminal context requires a much higher degree of recklessness and fault.
- [6] The issue for my determination is whether the Crown has proven its case on the three criminal charges beyond a reasonable doubt. That issue turns on various factors such as the factual findings at trial, the foreseeability of harm, the expert evidence, the regulatory duties of J. Cote and its senior officers, and the roles and responsibilities of the accused.
- [7] One important factor is the evidence of Thomas Richer, the pipelayer who was injured, about prior warnings and unsafe practices. Much of his critical evidence was contradicted by other witnesses and was strongly and effectively challenged by the defence at trial to the point where the Crown fairly acknowledged that certain aspects of his evidence were not fully reliable and must be approached with caution.

- [8] Another important factor is the role of the October 2, 2012, Geotechnical Certificate (the "October 2 Certificate") prepared by Edward Yip, the geotechnical engineer hired by J. Cote, who authorized trench work to proceed under certain conditions. Both Mr. Green and J. Cote submit that they put substantial reliance on the engineering certificate, which they thought authorized their work, but the reasonableness of their actions and reliance on the certificate is more complicated.
- [9] Ultimately, all three charges invite an assessment of the degree of carelessness, if any, exercised by Mr. Green and other senior J. Cote officers in the circumstances and the existence and extent of any departure from what a reasonable person or company would have done in the circumstances.

CIRCUMSTANCES

1) General Background

- [10] The 2012 Combined Sewer Separation Program that led to the wall collapse entailed excavation along the rear of the properties in the lane north of Edinburgh Street ("Edinburgh Laneway") (the "Project"). As noted, the Project involved replacing an old single combined storm and sewer line with separate storm and sanitary lines. The work took place on the Edinburgh Laneway, running from Gilmore Avenue North (to the east) to Boundary Road (to the west).
- [11] The Edinburgh Laneway existed on a hillside sloping down to the north and to Burrard Inlet from residential homes on Edinburgh Street. The laneway was bordered on the south side by residential driveways at the rear of each house. There were various retaining walls, carports, steps, fences, and foliage along the back lot of each residential property. The laneway was bordered on the north side by a steep-sloped park and undeveloped land that extended down to Burrard Inlet.

2) The Background to the Sewer Replacement Project

- [12] Mr. Geoff Tsuyuki was a professional civil engineer and the manager of contracts and inspections at the City of Burnaby in 2012. He provided background on capital works projects in general and the Project in particular.
- [13] Mr. Tsuyuki explained that, years ago, Burnaby and other municipalities commonly used a single sewer pipe that collected sewage and drainage water. This was thought to allow overflow into Burrard Inlet or the Fraser River in the event of heavy rain. Burnaby then began a program to separate old sewer pipes due to local treatment plants becoming overwhelmed.
- [14] The result was a series of smaller sewer separation projects across North Burnaby, which replaced the single pipe with two separate pipes for sewage and rainwater.

- [15] Mr. Tsuyuki explained the procedures involved in the tender process for city improvements. When a contract is put out for tender, the successful bidder becomes the general or principal contractor, or the "prime contractor" in the language of WorkSafeBC legislation. The general contractor may have one or more subcontractors.
- [16] Mr. Tsuyuki described the type of documents typically used in the ordinary course of a capital works project. The documents include the Master Municipal Contract Document (Gold Edition) ("MMCD"), the Tender Award, a Notice to Proceed, the individual contract signed by the prime contractor (here, J. Cote), and the pre-construction meeting minutes.
- [17] Certain general conditions were incorporated by reference into the contracts Burnaby signed with its contractors. These conditions are set out in the MMCD.
- [18] The MMCD is a lengthy document containing many standardized terms and conditions for municipal construction contracts. Most importantly for present purposes, the MMCD indicates in s. 4.2 that J. Cote bears sole responsibility for construction safety at the work site, in accordance with applicable safety legislation, regulations and codes, including the Workers Compensation Act, R.S.B.C. 2019, c. 1 [WCA] and related regulations, as well as best construction practices. Mr. Tsuyuki explained that as the prime contractor, J. Cote was the party that decided which trenching methodology to use and whether to get a trench certification from a geotechnical engineer.
- [19] The tender phase of the Project was followed by a design phase, during which the primary consultant was hired to complete the design and prepare it for tender. For this project, the primary consultant chosen was Vector Engineering ("Vector"), which had considerable experience in sewer, water and drainage projects.
- [20] The primary consultant's role was to design the project and create the construction program for tendering. Vector designed plans to separate the sewer and sanitation lines into a single trench.
- [21] The City also appointed Vector as the contract administrator--effectively, the City of Burnaby's overseer of the project. The late Rich Margetson, senior Vector Engineer, was the contract administrator responsible for ensuring the Project was completed and conformed to the approved design. Vector determined the location of the replacement lines within the laneway, relative to the existing pipeline. The location of the work being done was chosen before the tendering process was opened.
- [22] Vector retained EXP Services, a geotechnical engineering firm, to produce a geotechnical assessment report to guide the design team on ground conditions at the proposed project location. Mr. Ben Weiss, the principal of EXP and a senior geotechnical engineer, authored the EXP report.

- [23] On August 20, 2012, Vector recommended J. Cote for selection as the project's contractor. Subsequently, on August 29, 2012, the City issued a Notice of Award. This awarded the contract to J. Cote as the prime contractor to conduct the excavation work necessary to replace the existing storm and sanitary lines with new separated pipelines in a common or shared trench.
- [24] Once J. Cote submitted the necessary documentation and signed the agreement with the City of Burnaby, the City then issued a Notice to Proceed. The Project was to start in October 2012. The substantial completion date was set as December 7, 2012.
- 3) Design of the Sewer Replacement Project
- [25] Mr. Dennis Jung, an engineering technologist now retired, previously worked for Vector in 2012. He worked with Craig Walden, the main site inspector, and with Mr. Margetson, the contract administrator overseeing the Project.
- [26] Mr. Jung indicated that the original excavation design ran closer to the south side of the laneway alongside the residential properties, likely due to the existing infrastructure on the north side and the need to avoid a chlorine line on the opposite side. Some infrastructure, such as power poles, was located on the north side or Burrard Inlet side of the laneway. Mr. Jung testified that there was a chlorine pump station on the north side of the lane, which limited the design to being closer to the residential properties.
- [27] Mr. Weiss of EXP was tendered and accepted at trial as an expert in geotechnical engineering, geotechnical assessments and pavement design. His expertise included surface soil testing and examination of soil and groundwater conditions.
- [28] Mr. Weiss testified about his geotechnical engineering expertise and his two reports, which were admitted by consent at trial. He was a knowledgeable, impartial expert, and I generally accept his evidence.
- [29] Mr. Weiss's first report is dated February 10, 2012. It was prepared for the exclusive use of Vector as part of the preparations for the 2012 Combined Sewer Separation Program in Burnaby.
- [30] Mr. Weiss's report described assessments of two sites in Burnaby. Only the lane north of Edinburgh Street, described as Design 81960, is relevant to this case. Amongst other recommendations specific to the Project, he provided recommendations for excavation and dewatering (keeping water out) based upon a geotechnical engineering assessment of ground and soil conditions.
- [31] The ground conditions were described as, "Based on the finding from the test holes, excavation would generally be within existing compact sand and gravel/sand/silty sand fills with occasional cobbles and boulders." Mr. Weiss's report recommended the use of sloping if the trench walls were not supported; and "shoring should be installed at the top of the trench immediately after excavation." He further recommended that a "geotechnical

engineer should periodically review the soils encountered during excavation and make recommendations as warranted."

- [32] The use of these methods would help to address concerns over loose soil or sloughing and groundwater seepage, and changes in conditions, if any. These recommendations were intended to facilitate compliance with WorkSafeBC and applicable authorities.
- [33] Mr. Weiss defined the trench-bottom requirements for pipe bedding as compact sand and gravel, sand to silty sand fills, or native, dense, till-like soils. He identified potential zones of soft soil and outlined the excavation steps necessary to stabilize the trench base before installing the pipes.
- [34] Mr. Weiss's report supports the necessity of sloping trench sidewalls or installing shoring, even when ground conditions favoured pipelaying. EXP's scope did not include assessing adjacent hazards.
- [35] Mr. Weiss explained that his report concluded with a standard caveat that it was prepared for the exclusive use of their client, Vector.
- [36] J. Cote had access to the EXP report but was required to commission their own geotechnical engineering instructions in accordance with their agreement with the City of Burnaby.
- [37] Mr. Weiss explained that, during construction, it is better for a geotechnical engineer to use a test pit rather than drill holes. He agreed that an engineer on site, where excavation has already started, is in a better position to assess ground conditions than someone relying on a test drill hole. Such a person would be in a better position to make recommendations as warranted.
- [38] Edward Yip confirmed that this is what he was hired to do for J. Cote on the first day of excavation.

4) Craig Walden's Involvement

- [39] Craig Walden was a representative and construction inspector for Vector. On September 18, 2012, he took video footage of the project site to identify anticipated problems. The video includes images of adjacent structures to the proposed excavation. The video shows the retaining wall that fell over. This is the only audio-video recording of the retaining wall's pre-accident condition.
- [40] The pre-construction video shows numerous features of the laneway and records images of the subject wall that collapsed. The video shows a gap on the eastern side of the retaining wall. In the video, Mr. Walden refers to a large crack and notes displacement and bowing in the wall. However, Mr. Walden did not specifically flag the wall that fell for further examination. The video was not reviewed by Mr. Cote, who testified that it was better to walk the site in person than watch it on video. Mr. Cote denied that the separation Mr. Walden pointed out was a crack, calling it a construction joint instead.

- [41] No one from J. Cote reviewed or considered these recordings before the excavation work advanced into the subject portion of the lane.
- [42] Mr. Walden attended the Edinburgh Laneway regularly once the project began, as the site inspector to the contract administrator, Vector Engineering. He was not empowered to stop work if he saw a safety issue, though he could inform others of any concerns.
- [43] On the day of the accident, he attended the project site early in the morning, then left the laneway for other site visits. He received a phone call from Mr. Green in the minutes before the wall fell. Mr. Green asked to change the pipe bends to shorter radius bends, for which Mr. Walden declined permission. Mr. Walden later received a phone call again from Mr. Green about the wall collapse.
- [44] Following the accident, Mr. Walden attended the scene. He subsequently authored an inspection report detailing his observations and professional findings. Mr. Walden also recorded a post-accident video showing the removal of the collapsed wall.

5) The Pre-Construction Meeting

- [45] A pre-construction meeting occurred on September 19, 2012, chaired by Vector's Project Manager, Mr. Dennis Jung. Jamie Cote and his superintendent, Greg Trigg, attended, along with Vector's Contract Administrator, Rich Margetson. Mr. Green did not attend this meeting.
- [46] This routine mandatory meeting provided all parties with an opportunity to meet in person and to discuss the project, the costs, and concerns. The discussion was recorded by Mr. Jung, who created a written record in the form of minutes. The minutes were later reviewed and approved by all attendees.
- [47] The minutes reflect that the City confirmed that, as the prime contractor, J. Cote was responsible for ensuring coordination of occupational health and safety and compliance with the relevant provisions.
- [48] At trial, Mr. Tsuyuki confirmed that the minutes detailed their discussion about the adjacent improvements along the laneway that were of concern. The discussion about the structures adjacent to the excavation was not necessarily about potential hazards. Rather, it was a discussion about construction impacts and costs to manage the potential challenges during the excavation project.

6) The Work Crews on the Edinburgh Site

- [49] At the time of the incident, J. Cote was owned and operated by Jamie Cote. Gregg Trigg served as superintendent.

- [50] Mr. Green acted as the foreman and was the immediate site supervisor of the excavation near the site of the wall collapse. In this capacity, Mr. Green was directly responsible for directing the day-to-day activities of the excavation and pipelaying crew. The employees were not unionized.
- [51] Mr. Green's pipelaying crew comprised three workers: Marc Loiselle (an experienced equipment operator), Thomas Richer (an experienced tradesman), and the deceased, Jeffrey Caron. Mr. Caron was a younger worker who was relatively new to construction. Mr. Richer and Mr. Caron were responsible for entering the trench to cut, align, and install the pipe.
- [52] There was a separate crew involved in the work, consisting of Chad Allen as foreman, Kyle Waters, Brody Huizenga, and equipment operator Tom Bosman. Mr. Allen's crew followed behind Mr. Green's crew and operated in a support capacity, filling in the trench and cleaning up after Mr. Green's crew dug the trench and replaced the utility lines.
- [53] Mr. Green's practice was to attend the site each day at 6:00 a.m. to ready himself and his crew. His workers would attend closer to 7:00 a.m. to commence work at that time.
- 7) The Area in and Around the Retaining Wall and Trench
- [54] The retaining wall that collapsed was a concrete gravity wall located along the south side of the north lane of Edinburgh Street, west of Gilmore Avenue, in Burnaby. The retaining wall supported the backyards of the residences located at 4003 and 4009 Edinburgh Street.
- [55] The wall increased in height from east to west along the 4009 property. It then continued to the west at a constant height. Google Earth Street View photos taken prior to the wall collapse show a thin grassy strip between the bottom of the retaining wall and the paved lane. There was a relatively flat area immediately behind the top of the wall, before the backyard areas sloped gently up to the rear of the houses in Edinburgh Street. There were also garages some distance behind the retaining wall.
- [56] Mr. Thomas Whiffin is a longtime resident at 4003 Edinburgh Street, which is next door to the property at 4009 Edinburgh Street, behind which the main portion of the wall collapsed. Prior to 1975, he lived at 4015 Edinburgh Street.
- [57] Mr. Whiffin, who was referred to as a "sidewalk supervisor" at trial, testified about his observations and photographs of the laneway excavation project. He also provided historical context concerning the construction and maintenance of the retaining wall. Mr. Whiffin's evidence is objective, independent and credible. He was a neutral observer who had good insight into the Project's layout and the circumstances of the incident. I accept his evidence.

- [58] Mr. Whiffin was concerned about the excavation work being carried out so close to his property. He testified as to becoming upset and talking to an unknown worker about the proximity of the excavation to his property, expressing concern over the safety of the Project. I accept this evidence, though the worker he spoke to is unknown, and Mr. Whiffin may have been under a misunderstanding about the location of his property line relative to the laneway.
- [59] I also accept the evidence of workers from J. Cote, including Mr. Green, that they followed the plans and instructions they were given for the location of the trench along the laneway.
- [60] In terms of the depth of the trench, the photos of the trench behind Mr. Whiffin's property at 4003 Edinburgh (taken on October 10, 2012) show workers who were almost 6 feet tall standing in the trench. From the top of their heads, it appears the edge of the trench is three or four feet higher. Two of Mr. Whiffin's photos show Mr. Richer and Mr. Caron in the trench, which appears ominously to be about nine feet deep, perhaps more, at that point: Exhibit 13, photos 305-306.
- [61] The plan drawings called for a trench that was a maximum of 3.5 m deep at its lowest point at the beginning of the laneway, with a design depth of 2.5 meters (8.2 feet) to 3.0 meters (9.8 feet) from the lane surface to the underside of the pipe bedding. The plans called for the trench to run westward, gradually reducing in depth with a width of 2.225 meters.
- [62] Estimates of the actual depth of the trench near the site of the wall collapse ranged from 12' (Mr. Richer), 9' (Mr. Whiffin), 8' to 9' (Mr. Green), 6-7' (Mr. Huizenga), to 2.5 to 3 meters (Mr. Cote). Based on all the evidence at trial, I find that the trench was at least 8' deep in this area, from the top of the trench edge to the bottom of the trench (with certain fill in it). Of course, workers in the trench would have frequently been bending over as they worked on pipe work at the bottom of the trench. The result was that the top of the trench could be several feet over their heads at times, with a retaining wall above that adding to concern.
- [63] There was some minor sloping on the north side of the trench. There was no sloping on the south side of the trench, where the retaining wall was located. The south wall of the trench, where the wall collapsed, was completely vertical.
- 8) The Retaining Wall that Collapsed
- [64] The retaining wall or concrete gravity wall behind 4009 Edinburgh that collapsed was built in two sections, with a vertical "cold joint" between the sections in the middle at its highest point. The height of the wall varied across its length. It went from 0.9 meters (2.95 feet) on the eastern end to 2.1 meters (6.9 feet) toward the western end. The western portion of the wall maintained approximately the same height. Only 0.15 meters of the wall extended below ground. Thus, the above-ground height of the eastern section of the wall that toppled over varied in height from approximately 0.75 meters (2.46 feet) on the east to 1.95 meters (6.4 feet) on the western side.

- [65] The wall was approximately 0.6 meters (24 inches) thick at the bottom, tapering to 0.2 meters (8 inches) at the top. There was one drainpipe partway up the wall.
- [66] There was no defined footing to the wall. There were no tiebacks. There was no rebar reinforcing the wall or keeping it in place; only one thin piece of wire between the two main sections, which was grossly inadequate. It was simply a tapered concrete wall.
- [67] Mr. Whiffin provided detailed historical context regarding the construction and maintenance of the retaining wall behind the property at 4003 and 4009 Edinburgh Street. He explained that the original wall was built by the first owner of the property. This wall was a low cement structure, but Mr. Whiffin's father reinforced it in the late 1950s due to concerns over cracking and movement. The City's installation of a sewer line in the early 1960s lowered the grade of the land by approximately three feet and further exacerbated these structural issues.
- [68] Mr. Whiffin's father raised concerns with the city, and in the late 1970s, the city responded by constructing a new wall in 1976 or 1977 that extended from the original structure. Unfortunately, the new wall built by the city was essentially a vertical standing wall, with no footing or tiebacks. It therefore lacked structural reinforcement to prevent it from tipping. That wall remained in place until 2012, when it collapsed on the date of the incident.
- [69] I cannot agree with J. Cote's position that the wall collapsed due to a completely unexpected, defective retaining wall. Mr. Weiss made calculations that I accept involving a factor of safety for the wall. This safety factor is a calculation that compares the forces pushing on the wall to cause it to overturn with the resisting forces of the wall.
- [70] If resisting forces are lower, then the factor of safety is lower. Industry practice is to have a factor of safety of 1.5 or above. Without the trench, the wall's factor of safety was 1.8. The deeper a nearby trench, the lower the wall's factor of safety.
- [71] With this trench present, the factor of safety for this retaining wall against overturning was 0.7 based on site conditions (and slightly less than 1.0 for sliding). To prevent failure, the wall base needed to be four feet thick instead of two feet (and the wall's stability would still be marginal at that level, with a factor of safety of 1.0). Dr. Hamidi agreed that removing the soil in the trench below the wall prevented the wall from resisting sliding forces. In other words, excavating the trench made the wall completely unable to resist collapse. It was not a close call. I reject the argument that the wall's collapse was wholly or even substantially due to the poor construction of the wall alone.
- 9) The Distance from the Trench to the Retaining Wall
- [72] The trench was immediately adjacent to property lines and structures, including fences, a basketball pole, and the retaining wall at 4009 and 4003 Edinburgh Street.

- [73] As noted, Mr. Whiffin took photographs of the work at the site. Those images substantiate the trench location and provide an objective record of the site conditions at the time of the incident.
- [74] The photos Mr. Whiffin took of the trench behind his property line show the edge of the trench appearing, in some discrete areas, to be closer than two feet to the wall behind Mr. Whiffin's property. In one photo, the edge of the trench appears to be about 18 inches from the retaining wall behind his home. That photo shows a four-inch diameter orange hose along the wall, and the distance from the edge of the trench to Mr. Whiffin's retaining wall appears to be 3-4 times the diameter of the hose. Various estimates at trial ranged from just over two feet from the edge of the trench to the retaining wall to just under two feet.
- [75] There are no photos of the trench behind 4009 Edinburgh, and hence the Court has to rely on testimony, evidence from the circumstances, and inferences from the location of the trench at 4003 Edinburgh.
- [76] Based on all the evidence, I find that the edge of the trench was located at approximately two feet from the vertical portion of the retaining wall behind 4009 Edinburgh. The Crown has not proven that the edge of the trench was closer than two feet to the vertical portion of the wall.
- 10) Thomas Richer - Pipelayer for J. Cote, Injured in the Trench Collapse
- [77] Thomas Richer was a pipelayer employed by J. Cote at the time of the incident. He testified about the events of October 11, 2012, including the working conditions at the Project site, the conduct of supervisors and crew members, and his observations both before and during the fatal trench collapse that claimed the life of Mr. Caron.
- [78] I will deal with Mr. Richer's evidence in some detail because of its potential importance to the Crown's case. At a general level, I accept some of Mr. Richer's evidence. As I explain below, due to certain credibility concerns, I cannot accept all aspects of his evidence.
- a) Credibility
- [79] Counsel for Mr. Green invites me to reject Mr. Richer's evidence in its entirety as outrageous and unbelievable. J. Cote's position is similarly that Mr. Richer's evidence is far too unreliable to be relied upon. The Crown submitted that some of Mr. Richer's evidence must be treated with caution, partly because of the psychological trauma he endured, but suggested I should accept some of his evidence.
- [80] Mr. Richer is an enigmatic individual. He presented as a knowledgeable and experienced pipelayer. Like Mr. Loisel, the excavator operator, Mr. Richer was clearly profoundly affected by the post-traumatic effects associated with the incident. When the wall collapsed, and without concern for his own safety, Mr. Richer re-entered the trench to try in vain to save Mr. Caron. He watched Mr. Caron die in front of his eyes. Later, he lobbied for criminal charges in this matter, made posters and buttons, and gave interviews and made speeches

demanding justice for Mr. Caron.

- [81] Yet, much of Mr. Richer's evidence on key points was contradicted by other reliable evidence that I accept, not corroborated, possibly exaggerated, or suspect. Mr. Richer has a lengthy but dated criminal record from his younger years, a factor I do not find significant in this type of case, to the extent it is based on the observations of witnesses. However, given other, more significant concerns about his evidence, I cannot fully accept Mr. Richer's evidence on key points.
- [82] While I accept some of Mr. Richer's evidence on uncontroversial matters, I cannot accept the substance of his more damaging evidence on critical issues because of these credibility concerns. However, I do accept his evidence on peripheral matters. I also accept his evidence in discrete areas where it is corroborated by other evidence.

b) Background

- [83] Mr. Richer began working as a pipelayer for J. Cote in the summer of 2012, around June or July. He testified that he received a phone call from Jamie Cote instructing him to report to a job in Burnaby, after which he arrived on site and began working. Over the course of his employment, he worked on six or seven different worksites. He ceased working for J. Cote after the incident.
- [84] Mr. Richer's work history included time working as a pipelayer at well-established firms in the construction and excavation industry. He demonstrated familiarity with construction industry practices and standard safety protocols such as daily toolbox talks, trench shoring procedures, and PPE compliance. He also took photos at prior worksites and was able to describe certain workplace conditions with the benefit of photos tendered at trial.
- [85] Mr. Richer provided an overview of the company's structure and key personnel. He confirmed Mr. Cote as the owner, Mr. Trigg as the superintendent, Mark Loiselle as the excavator operator, Mr. Huizenga as a pipe labourer, Mr. Allen as a foreman for a separate crew, and Mr. Green as the foreman on his crew. Initially, Mr. Richer worked alongside Ted Grey, who later quit and was replaced by Jeffrey Caron.

c) Mr. Richer's Evidence that he Warned Others

- [86] Mr. Richer described Mr. Cote coming to the site every other day. Mr. Richer specifically stated that he talked to Mr. Cote on Wednesday, October 10, 2012. He testified that he asked him about a raise. He told Mr. Cote that the trench was unsafe and that "they shouldn't be in there."

- [87] Mr. Cote testified, and I accept, that he attended the scene on October 3, 2012, which would be the day after Mr. Yip issued his certificate to start excavation. However, flight records filed at trial show that Mr. Cote travelled out of town on October 7, 2012, and returned on the afternoon of October 11, 2012. Mr. Cote was not at the scene in the days immediately preceding the wall collapse and was not in town the day Mr. Richer described having the conversation with him.
- [88] As well, Mr. Richer described a narrative in which Mr. Loiselle, the excavator operator, looked at the wall on the morning of the collapse, saw a white scrape mark, and said, "Did I do that?" Mr. Richer said he told Mr. Green that the wall was failing, and that Mr. Green responded, "We just have to keep going, we'll get past this." Mr. Richer reported that Mr. Green said he would keep his eye on the wall and yell at them if it was moving.
- [89] Mr. Loiselle and Mr. Green, whom Mr. Richer reported were present, denied this evidence. I accept their denial. I find that the mark on the wall Mr. Richer was referring to was clearly made after the wall collapse when Mr. Loiselle frantically used the excavator bucket to attempt to lift the wall from its position on top of Mr. Caron in the ditch. I cannot accept Mr. Richer's evidence about a conversation about a visible separation at the cold joint in the wall, or Mr. Richer's vocalization of this concern.
- [90] Mr. Richer described Mr. Green as running away after the incident. As Mr. Richer put it, he told Mr. Green to call 911, but "our fearless foreman" ran scared from the scene instead. In fact, however, I find that Mr. Green was directing help to the scene while simultaneously on the phone with 911. He was running down the laneway to quickly obtain an address so that emergency vehicles could be directed to the scene. The description of Mr. Green as running away is unfair and inaccurate. At times, Mr. Richer appeared to harbour animosity toward Mr. Green, though he also referred to J. Cote as a "bunch of good people" and Mr. Green as "a good man."
- [91] Mr. Richer described the worksite as especially dangerous and said he initially refused to work in the trench because of its condition and appearance, acting as the "top guy" instead in the early days of the Project. Mr. Green and Mr. Loiselle disputed this account, and I cannot accept this part of his evidence.

11) The Collapse of the Retaining Wall

- [92] From October 2 to 11, 2012, Mr. Green's crew worked their way westward. By October 10, 2012, they were at Thomas Whiffin's property at 4003 Edinburgh, seven houses along the laneway. On Thursday, October 11, 2012, the day of the accident, they were behind 4009 Edinburgh, the eighth house, and directly adjacent to the retaining wall.
- [93] Mr. Loiselle, the excavator operator, dug alongside the trench and below the surface of the laneway to extend the trench westward.

- [94] Mr. Richer and Mr. Caron had just completed a sanitary sewer tie-in. They entered the trench to begin work on a storm tie-in, which required further excavation along the trench.
- [95] As discussed above, I cannot accept Mr. Richer's evidence about a conversation with Mr. Green and Mr. Loiselle regarding a visible separation at the cold joint in the wall or Mr. Richer's vocalization of concern at that point. I do accept that Mr. Richer was concerned about the depth of the excavation and working without shoring, that he spoke about it to Mr. Green at some point, and that Mr. Green showed him a coloured copy of the geotechnical certificate for the Project.
- [96] After the mid-morning coffee break, Mr. Richer and Mr. Caron re-entered the trench to resume work. Mr. Green was directing work from the top of the trench. Mr. Loiselle was working on the excavator.
- [97] Brody Huizenga, who was assigned to the second crew working nearby, brought a pipe-cutting saw and left it at the top of the trench. He entered the trench to retrieve another saw that wasn't working and exited the trench with it. Mr. Caron and Mr. Richer were still in the trench working, and Mr. Caron started the saw to cut a piece of pipe to connect the line to a neighbouring property at 4009 Edinburgh Street.
- [98] Shortly thereafter, Mr. Green shouted for the crew to get out. Almost immediately, the retaining wall gave way and collapsed into the trench. There is some disagreement about whether the wall tipped or rolled over, but it is clear that the wall failed and collapsed.
- [99] Mr. Caron was pinned against the trench wall. I find that the tallest portion of the retaining wall, near the cold joint separating the two main pieces, collapsed onto him. He sustained catastrophic blunt force trauma from the wall hitting him.
- [100] Things happened quickly. Mr. Green gave directions and called for assistance on his phone. Mr. Green told Mr. Huizenga to alert the other crew and have the other excavator brought over. Tom Bosman from the second crew drove a backhoe or excavator over to the site of the wall collapse.
- [101] Marc Loiselle and Brody Huizenga undertook rescue attempts. Using the excavator, Mr. Loiselle attempted to lift the collapsed wall in order to release Mr. Caron. Mr. Bosman assisted with his excavator or backhoe after he brought it to the scene. When Mr. Loiselle lifted the wall, Mr. Caron slid further into the trench. Mr. Richer returned to the trench to check whether Mr. Caron was still alive. Mr. Caron was unconscious and non-responsive.
- [102] Mr. Green directed Mr. Huizenga to run down the lane to direct first responders to the site. Fire department rescuers arrived soon thereafter and were able to pull Mr. Caron out of the trench. He was transported to the hospital and pronounced dead shortly after his arrival.
- [103] Mr. Richer was also struck, suffering serious injuries to his head, legs, and ribs. He managed to partially free himself from the debris.

[104] Mr. Richer was also transported to the hospital following the incident. Although medical staff advised him to remain at the hospital, he chose to leave. His back pain remained chronic. At trial, he spoke at length about the psychological toll the incident had taken on him. He described experiencing persistent trauma, symptoms consistent with post-traumatic stress disorder, and emotional instability in the aftermath of the collapse. He testified that, at one point, the impact on his mental health became so severe that he attempted to take his own life. I accept Mr. Richer's evidence that he suffered these physical and psychological injuries. I find that they amount to bodily harm within s. 2 of the Criminal Code.

12) Certification of the Trench Work

[105] J. Cote hired Edward Yip, a geotechnical engineer, to do an inspection on Tuesday, October 2, 2012, the first day of excavation, and to provide a certification for the new trench as safe for worker entry. His certificate, a copy of which is appended to these Reasons as Appendix A, is a major source of controversy in this case and warrants careful consideration.

a) Mr. Yip's Background

[106] Mr. Yip had worked as a geotechnical engineer since the 1980s and had considerable construction and engineering experience related to excavation. He worked for Earthbitat Engineering Ltd. ("Earthbitat"), a company he started in 1997.

[107] Mr. Yip's considerable experience included the geotechnical design and development of underground services and large above-ground utilities, as well as the engineering design of structures requiring slopes, excavation, and soil stabilization. He had successfully managed projects involving excavation and backfilling, as well as the construction of large-scale building foundations. He had worked for many excavation companies prior to 2012 and had been working with J. Cote since 1993 or 1994. He estimated he had done up to 200 certifications for J. Cote; typically, he was called out to certify utility sewer trenches.

b) Mr. Yip's Understanding of His Role

[108] Mr. Yip described the content of a certification as stipulated by WorkSafeBC and the Occupational Health and Safety Regulation ("OHSR"). Mr. Yip testified, and I accept, that a geotechnical engineer's certification is necessary to begin excavation work, unless the contractor chooses to use shoring or a trench box to ensure the safety of the workers. He explained his understanding that s. 20.81 of the OHSR prohibited trenching deeper than four feet without shoring, sloping or a trench box unless a qualified registered professional, such as himself, was to provide certification that the trench was safe for entry.

[109] Mr. Yip pointed out that the OHSR has specific calculations to identify which structures or improvements are considered "adjacent" to a trench excavation. It also provides options for the contractor if conditions change, such as using a shoring cage, sloping, benching the slope, or consulting an engineer to determine if it is safe to enter.

c) Mr. Yip's Attendance at the Edinburgh Laneway

- [110] Mr. Yip described arriving at the Edinburgh Laneway around midday on October 2, 2012. He noted that workers were on site at the Edinburgh Laneway. Mr. Green, the foreman, greeted Mr. Yip. Other than cordial greetings, they had no discussion about the excavation project. Mr. Yip explained that he had worked with Mr. Green many times and hence there was no need to discuss the nature of the work to be done.
- [111] To prepare the certification, Mr. Yip asked for the master plans and extracted the information he believed to be relevant for his certification. He returned the plans to Mr. Green. After partially reviewing the design plans, Mr. Yip diagrammed the manholes and calculations of the new trench. Mr. Yip immediately entered the new trench, which he described as a giant test hole. This four-metre trench or hole was situated at the farthest east end of the Edinburgh Laneway, near the beginning of the lane.
- [112] Mr. Yip evaluated soil composition and its various layers within the trench. He drafted a certificate report from inside his car. The process took about two hours.
- [113] Originally, the certification was to expire on Friday, October 12, 2012, ten days after the certification. This was a two-week period that included Thanksgiving, leaving only nine working days. Mr. Green advised Mr. Yip that his service cost the company a lot of money, so he wanted a slightly longer period for the certification. I accept Mr. Yip's evidence that this statement was made.
- [114] Mr. Yip agreed to extend the certification to the following Monday, October 16, 2012. The certification was then in effect from Tuesday, October 2, 2012, until Tuesday, October 16, 2012. Mr. Yip extended the certification to October 16 because he had worked with J. Cote for over a decade, and he trusted them.
- [115] WorkSafeBC required excavation contractors to keep a copy of the geotechnical certificate on site so they could review it whenever they attended. Mr. Yip explained the distribution of the colour copies. The white copy was the original given to the foreman. Pink or green is given to the contractor. Yellow is the copy that Mr. Yip kept for his own business record.
- [116] Mr. Richer recalled seeing a coloured copy of the geotechnical certificate during the trench project. He said that Mr. Green showed him this colour certificate when he expressed his concern about the trench being so close to the wall. I note that the Crown did not show Mr. Richer the coloured, nor any other, copy of the certificate in his preparation for trial. I accept that at one point, Mr. Green showed Mr. Richer a copy of the October 2 Certificate.
- [117] Mr. Yip testified, and I find, that he did not walk the laneway with Mr. Green on October 2, 2012. I make this finding despite Mr. Green's evidence (and to some extent Mr. Allen's evidence) to the contrary. Mr. Yip testified that he was called out to the excavation at the start of the project to certify the initial entry and spent 2.5 hours on his assessment. Walking the lane would require extra time, which was outside the scope of the request. There was no service agreement or ongoing retainer. The terms of the service were

embodied in his invoice, which he gave to Mr. Green immediately that day. In the alternative, if Mr. Yip did happen to walk up or down the laneway at some point with Mr. Green, I find that he certainly did not make any assessment of or discuss the soil below or nearby structures or hazards.

d) The Earthbitat Geotechnical Certificate

[118] Mr. Yip's October 2 Certificate indicates as follows near the top of the first page (the italicized portion is handwritten):

Re: Inspection of the Trench / Excavation: At the lane north of Edinburgh St, intersection with Gilmore Ave, heading west to Boundary Rd, Burnaby, B.C.

This report summarizes our Oct 02, 2012 field geotechnical inspection of the subsoil / groundwater conditions and stability assessment of the subject trench / excavation located at the above-referenced site in accordance with The Occupational Health & Safety Regulations No. 20.78-20.95 of WorksafeBC.

[119] This language is then followed by a "Drawing / Sketch Plan and Cross-Sections of the Subject Trench / Excavation." The drawings below on the first page include a drawing of the laneway showing manholes at various locations, and a cross-section of the trench.

[120] The second page of the October 2 Certificate references "Lane north of Edinburgh St. at intersection with Gilmore Ave, Burnaby, B.C." It contains various conditions, the second of which is as follows (again, handwritten portions are in italics):

- 2) Limitation when machinery, load and/or vibration are in proximity: Keep heavy loads/ vibration of high intensity minimum 0.6 m setback away from the trench excavation cut edges lest soil failures may occur due to overstress imposed in too close proximity. Do not sidecast spoil along the trench edges.

[Emphasis added.]

[121] Condition 2 is critical. It is important because it dictates how far away "heavy loads" are to be kept from the edge of the trench. It was the subject of a calamitous misunderstanding between senior officers of J. Cote and Mr. Yip.

[122] Condition 3 dealt with inclement weather. Mr. Yip noted on the certificate that the presence of excessive water would cause soil to become unstable, especially the upper layers. There is admission by the Crown and the accused that the weather was dry during the two-week initial period of this excavation.

[123] Condition 4 of the Certificate indicated as follows:

- 4) Recommendations and confirmation of site review: "Based on the field inspection of the subsurface soil and groundwater conditions, the common trench with details shown on page 1 is deemed:

safe for entry by workers to carry out below-grade pipes/fitting installation works, without use of any shoring systems and without having the trench sidewalls sloped or benched cut to tilting backward with minimum flat angle of 3/4H:1V.

[Emphasis added.]

[124] This condition effectively means that the workers did not have to make a slope for the excavation wall. Again, there is disagreement as to the meaning of this condition. The dispute is whether it applied only to the initial location or to the entire laneway.

[125] Conditions 5 and 6 of the Certificate read as follows:

- 5) Time period for which the certification applies. Provided that no adverse change in underground soil/water conditions and the trench edge unloading condition, this certification may apply until October 16, 2012.
- 6) Supplementary instructions contrary to instructions originally issued on previous visit(s). Where unstable spots are encountered on the trench sidewalls, spot shoring shall be installed to provide local stabilization of the unstable soil walls.

[126] Mr. Yip explained that the supervisor could use spot shoring, such as a small trench box, or cages which have steel plates, struts and cross braces. When asked about unstable spots, he explained that all experienced contractors know what can create problems.

[127] Mr. Yip explained that contractors know to remove nearby hazards or "nearby structural improvements." Examples included garages, trees, utility poles, boulders, garage foundations, and retaining walls. These must be dealt with by the contractor.

[128] Mr. Yip explained that ss. 20.78-20.94 of the OHSR allowed contractors to use shoring, cages, and benching. In his view, the contractor does not have to contact an engineer to use the aforementioned methods of spot shoring. When a shoring cage is set up, the WCB field officer can be contacted to check the setup without the contractor hiring an engineer to check it, when the contractor does not want to pay an engineer.

[129] Condition 7 indicated the names of persons who must report adverse or destabilizing changes. It read as follows:

- 7) Name of designated foreman, superintendent or person in charge on site who must report any adverse/de-stabilizing changes in the subsurface soil and groundwater conditions to the undersigned engineer for further specific field review and safety recommendations. Gregg Trigg or Dave Green.

[130] Mr. Yip noted that the OHSR required a designated person on site at all times to bear this responsibility.

[131] Mr. Yip did not explain his instructions but instead provided his certificate and copies to the foreman, Mr. Green, at the jobsite.

[132] Mr. Yip testified, and I accept, that his focus on October 2, 2012, was only on the initial trench and not on any adjacent structures. He conducted no soil testing elsewhere along the laneway. He expected to be called back if ground conditions changed or if hazards were encountered next to the excavation, but he never was until after the trench collapse.

[133] Mr. Yip noted that J. Cote had the option of using a shoring cage. He thought that if they did not seek further consultation, they had to use shoring.

e) Post-incident Involvement by Mr. Yip

[134] After the wall collapsed, Mr. Yip received a phone call from Mr. Trigg to inform him of the incident.

[135] J. Cote could not resume work until all affected walls were inspected and the trench was relocated. To lift the stop-work order, J Cote hired Mr. Yip to certify all the adjacent structures along the new trench design.

[136] The prime consultant, Vector Engineering, had to realign the sewer pipes accordingly. Mr. Yip was not involved in the engineering redesign or relocation of the trench away from the property line. That work was completed by the prime consultant, Vector.

[137] During that post-incident period, Mr. Yip was engaged in performing a detailed assessment and design for shoring requirements for J. Cote. Mr. Trigg retained him to carry out the detailed shoring design. His November 7, 2012, certificate provides detailed references to every structure along the new trench pathway. J. Cote points out that the November 7, 2012, certificate expresses that "heavy concentrated loads" such as "building foundation, retaining wall footing" must not be allowed to impose closer than 1.2 m from the top cut edges of the trench. However, I do not find that this fact in the November 7, 2012, certificate has significant interpretive value reaching back in time to the October 2 Certificate, because the November 7 certificate was written after the wall collapse, and that event may have prompted Mr. Yip to correct J. Cote's misunderstanding. I find as a fact that Mr. Yip did not intend to assess the proximity of adjacent structures in his earlier certificate, and he made no specific assessment of them when he visited the site on October 2, 2012.

f) Professional Disciplinary Process re Mr. Yip

[138] As a result of a disciplinary process by the Engineers and Geoscientists of British Columbia ("EGBC"), Mr. Yip admitted to unprofessional conduct related to his geotechnical inspection report prepared in 2012 for the excavation at Edinburgh Laneway, the same excavation which is the subject of this proceeding. The October 2 Certificate was found to have failed to comply with s. 20.78 of the OHSR. Mr. Yip retired in 2022 and voluntarily resigned from EGBC on December 5, 2022. His professional registration was cancelled.

13) Prior Unsafe Practices

[139] Mr. Richer testified about safety concerns at worksites prior to the Project. His testimony regarding such incidents is uncorroborated and, in most cases, contradicted by other witnesses. I am unable to accept Mr. Richer's testimony as to prior unsafe practices by Mr. Green or J. Cote in general.

14) Whether Mr. Richer Raised Concerns with Others about the Safety of the trench

[140] Mr. Richer claimed to have raised concerns about trench safety to multiple individuals, including Dave Green, Jamie Cote, Mark Loiselle, and Craig Walden. He described a general reluctance among supervisors to address these concerns.

[141] All of these witnesses denied Mr. Richer's evidence about raising prior concerns. I cannot accept Mr. Richer's evidence that he warned these individuals about the safety of the retaining wall prior to the wall collapse, except that he, on one isolated occasion, engaged in a discussion with Mr. Green about the proximity of the retaining wall and was shown the October 2 Certificate.

15) Whether the Soil Conditions Changed

[142] Mr. Richer stated that the soil conditions on the project changed and worsened as they worked to the west, to the point where the soil was sandy and loose at the site of the wall collapse. I cannot accept this evidence.

[143] Mr. Loiselle, the excavator operator, was perhaps best placed to make comparisons about the density, hardness, and quality of the soil as he dug his way down the lane. He testified that the soil at the accident scene remained hard and good and that it didn't vary significantly.

[144] Mr. Green similarly testified that the soil conditions did not change. Mr. Yip returned to the project site after the accident and viewed various photos of the trench. He testified that the ground conditions did not change and that there was still very hard ground around the site of the wall collapse. The only sloughing he observed was around the site where the connection pipes going to houses had been dug out in the past. Mr. Weiss, another geotechnical engineer, agreed that the soil was hard and the ground conditions did not change.

16) WorkSafeBC Investigators

a) Lonny Bouchard

[145] Mr. Bouchard is a retired WorkSafeBC investigator who attended the Edinburgh Laneway on October 11, 2012, following the fatal incident, alongside Gary Anderson. At the time, Mr. Bouchard was part of the Fatal and Serious Injury Investigation (FSII) division, responsible for both incident causation assessments and audits of employer safety programs.

- [146] Upon arrival at the site, he documented the scene with photographs and canvassed the neighbourhood, ultimately receiving drawings and letters from Mr. Thomas Whiffin regarding the retaining wall's construction.
- [147] Mr. Bouchard identified multiple hazards at the site, including an unstable bank and the absence of trench shoring. He noted that the trench posed a further risk due to the unstable bank and absence of shoring. He did not observe any safety infrastructure in place to mitigate this hazard.
- [148] Following standard FSII procedures, Mr. Bouchard issued a document request to J. Cote under s. 179(3) of the WCA. The directive was addressed to Greg Trigg, the site superintendent, and sought a broad range of records intended to assess employer due diligence, including safety training, engineering documentation, audit reports, disciplinary policies, and joint health and safety meeting minutes. To the best of Mr. Bouchard's recollection, no substantive documentation was provided in response, aside from an outdated safety manual.
- [149] Mr. Bouchard testified that company safety manuals are expected to be updated annually.
- [150] The lack of J. Cote documentation aligns with witness testimony, which indicated that the company's safety practices were informal and inconsistently documented.
- [151] Mr. Bouchard identified physical hazards at the site and noted the absence of key safety documentation following his request to the employer. As part of his role, he subsequently issued several orders under the OHSR and the WCA. These included requirements for a formal health and safety program (s. 3.1), orientation for young or new workers under 25 (s. 3.23), the obligation to conduct health and safety meetings (s. 3.3), and the duty to report hazardous conditions (s. 3.10). He also referenced a directive provision under s. 1.94. Mr. Bouchard's explanation highlighted that these orders are corrective and preventive, intended to ensure compliance with safety regulations and prevent similar incidents in the future.
- b) Mr. Fielding
- [152] Douglas Fielding testified that he was a WorkSafeBC occupational safety officer at the time of the incident. Mr. Fielding has extensive experience in heavy industry and construction safety. He was not called as an expert witness, but his background informed his observations.
- [153] Mr. Fielding attended the site at Edinburgh Laneway on October 11, 2012, at approximately noon, following a dispatch. He was responsible for assessing safety conditions, identifying hazards, and initiating compliance measures in accordance with his role.

- [154] He walked the site and took photos, which were admitted as exhibits at trial. Mr. Fielding described, and I accept, that there was a large shoring cage located down the laneway near a C-can where the trench first began, though the shoring cage is not visible in the photos entered at trial.
- [155] Mr. Fielding did not issue a formal stop-work order himself. He explained that work had already stopped by the time he arrived, due to the incident and the investigation being conducted by other officers. However, he told the employer that work could not restart until approved engineering instructions were provided and a satisfactory compliance plan was in place.
- [156] Mr. Fielding spoke with Mr. Cote the following day, October 12, 2022. Mr. Cote confirmed that his company had signed on as the prime contractor.
- [157] Mr. Fielding issued a written inspection report on October 13.
- [158] Mr. Fielding requested that J. Cote, as the employer, provide a formal incident investigation report, as required under Part 3 of the WCA. He also asked for documentation of toolbox meetings, revised safe work procedures, and engineering input to address the retaining walls and other hazards along the lane.
- [159] Mr. Fielding received an initial incident investigation report from J. Cote on December 7, 2012. On December 18, Mr. Trigg asked to provide a revision, which was permitted.
- [160] Mr. Fielding clarified that he expected the employer to identify causes and steps for prevention, but emphasized that he did not tell them what to include in their report. His role was to evaluate whether the submission was satisfactory, and in this case, he was focused on immediate corrective actions. Broader or longer-term oversight was the responsibility of other WorkSafeBC officers.
- 17) Mr. Weiss's Investigation
- [161] WorkSafeBC required changes to the excavation plan before lifting the stop work order. Vector Engineering was retained to plan the redesign of the excavation project. In the process, Vector hired EXP to conduct a geotechnical engineering assessment of the causes of the wall failure.
- [162] Mr. Weiss, the geotechnical engineer who helped design the project, produced a report dated December 18, 2012, addressing the reasons for the retaining wall failure on the Edinburgh Laneway.
- [163] To prepare this report after the incident, Mr. Weiss attended the site to take measurements and make observations. There was no groundwater in the trench when he visited. The soil conditions did not appear to have changed.

[164] He testified that he wanted to understand the conditions of the wall and to determine the stability of the collapsed wall with the trench in front of it. He also obtained anecdotal information from the contract administrator, the late Mr. Rich Margetson. His assessment included calculations of the factors of safety against overturning, sliding, and passive soil pressure. He also looked at what the width of the wall should have been to avoid sliding or overturning.

[165] Mr. Weiss explained that these are mechanisms that cause a retaining wall to move. He indicated that gravity walls are relatively common and, generally speaking, are concrete masses that resist whatever is behind them. He cautioned that the term "failure" is nebulous.

[166] Mr. Weiss testified that the weight of a structure is only one component of the factors of safety and resistance. He opined that a "load" refers to a force acting downward. He agreed that anything with weight due to gravity creates a load. Typically, walls are designed to rotate out slightly at the top because there is nothing bracing them.

[167] Mr. Weiss concluded as follows in his December 2012 report:

The above findings from the geotechnical assessment show that the existing wall was in our opinion likely in progressive over-turning failure mode prior to the trench excavation, just marginally stable with respect to sliding and globally stable. The fact that there did not appear to be a complete failure of the wall prior to the excavation as the calculations would imply may possibly be due to factors such as the actual active pressure coefficient being less than the assumed value and contribution of passive resistance at the toe. It is our opinion that the effect of the trench excavation with vertical or near vertical unsupported trench sidewalls would have "relaxed" and caused some movement of the soils at the toe of the wall towards the trench, thereby likely putting the already marginal wall into a sliding failure mode, further decreasing the resistance to over-turning, as well as initiating a global stability failure mode. The sliding and over-turning mechanisms were likely more of an immediate effect than the global/circular rotation failure mode based on the actual wall movements that occurred. Further, the full height rectangular section of retaining wall would have been the least stable to begin with, and therefore, most prone to destabilization from the removal of soils as a result of the trench excavation. This would seem to support the information provided by the excavator operator that he first noticed sliding out of the rectangular section of the wall.

With the likelihood of the removal of the soils in front of the wall being the triggering event that caused the movements of the already marginally stable retaining wall, we would point out that the installation of active shoring for the trench sidewalls would have provided effective lateral restraint for the adjacent soils, and therefore, timely installation of shoring would likely have prevented a catastrophic failure of the retaining wall.

For information purposes, using the above stated assumptions, we have calculated that the wall base would needed to have been 4 feet thick versus the actual 2 feet thick base in order to satisfy commonly accepted factors-of-safety for sliding and overturning without the presence of the

trench. With this increased wall base thickness, we have calculated a factor-of-safety of approximately 2.5 against global instability without the trench and approximately 1.0 after trenching. Therefore, it appears that there would still have been a possibility that the wall could have experienced significant movement in a global stability failure mode without active shoring of the trench; however, it is our opinion that the risk of a rapid, catastrophic failure such as the toppling that was experienced would have been significantly lower.

[Emphasis added.]

[168] Although Mr. Weiss testified that the wall was in progressive overturning mode, he did not have sufficient information on the wall to be certain.

[169] Dr. Hamidi adopted this description of the wall failure but added that he disagreed that the wall was in progressive overturning mode. Both engineers agreed that the wall had remained stable for many years until excavation undermined the soil beneath it. On balance, I would not accept Mr. Weiss's opinion that the wall was in progressive overturning mode, though I do accept that the wall was prone to overturning if the soil beneath it was disturbed.

18) Dr. Mehrdad Hamidi

[170] Dr. Mehrdad Hamidi is a senior structural and civil engineer with over 35 years of experience in analysis, design, and construction supervision. He holds a master's degree in civil engineering and a PhD in earthquake engineering and has extensive experience in the engineering industry on various projects, including working with retaining structures and assessing soil behaviour. Dr. Hamidi joined WorkSafeBC in 2014 and has spent 11 years applying and enforcing safety regulations and standards across various work environments, including construction sites, trenching operations, and retaining-wall projects. He has regularly reviewed excavation geotechnical certificates to ensure regulatory compliance and consults with field officers, employers, manufacturers, and workers to promote safe practices.

[171] The Crown tendered Dr. Hamidi as an expert in civil and construction engineering to address the engineering standard of care that applied to construction excavations. Following a voir dire, I accepted him as an expert in these areas; and more specifically, as an expert in a) the design of structures such as retaining walls, airplanes, and buildings; b) the assessment and measurement of loads, soil pressure, soil capacities, and the interaction of the retaining walls in relation to the surrounding or supporting soil conditions; c) the structural design of foundations, including soil behaviour and geotechnical factors; (d), the practical aspects of geotechnical certificates and their appropriate application; and e) the practical aspects of applying the OHSR standard practices and guidelines in the industry.

[172] Counsel for Mr. Green criticized Dr. Hamidi as a "hopeless witness" whose evidence ought to be rejected. Counsel for both accused cited various criticisms, including deficiencies in Dr. Hamidi's knowledge, bias, lack of a basis for his opinion on the standard of care,

backward reasoning and logical flaws, and failing to understand the October 2 Certificate. I do not agree with these criticisms. While I would be vigilant in monitoring the scope of his evidence, I found Dr. Hamidi to be very knowledgeable and his evidence helpful in understanding the technical aspects of trenchwork, retaining wall design, industry practices, and geotechnical certificates.

- [173] Dr. Hamidi's opinion evidence is summarized in two reports: an original report of January 29, 2021 (the "Original Report") and a supplemental report with answers to certain questions prepared (at the request of all counsel) just prior to his evidence commencing (the "Supplemental Report"). As is indicated by the stated purpose of his report, Dr. Hamidi's Original Report was prepared for the RCMP to first provide an engineering opinion on the reason for the collapse of the retaining wall, and second, to opine on whether the excavation was compliant with the OHSR and the WCA.
- [174] Despite the provenance of his reports, which I take into account, I am satisfied that Dr. Hamidi understood his duties as an impartial expert to assist the court.
- [175] At trial, I was careful to limit Dr. Hamidi's evidence and edit his reports so that he did not opine on the central questions of whether certain field conditions were illegal and whether J. Cote or its agents breached a legal duty. To the extent he departed in his testimony from purely technical opinion in suggesting that regulations or duties were breached, I would ignore such evidence. In other words, his opinions were confined to matters of fact and not law.
- [176] In terms of the content of Dr. Hamidi's opinion on the reason for the wall's collapse, he explained that the main reason for the wall's collapse was the sliding failure of the soil supporting the wall. The excavation significantly reduced the passive resistance served by the soil in front of the wall. With the trench in front of it, the narrow strip of soil was insufficient to prevent the wall from sliding under lateral soil pressure behind it. Consequently, the wall slid and fell into the trench.
- [177] With respect to the October 2 Certificate, Dr. Hamidi noted that the certificate did not refer to the retaining wall as part of the certification. He opined that the absence of any reference to adjacent structures in the instructions rendered the certificate incomplete.
- [178] With respect to nearby structures, Dr. Hamidi testified that engineers do not treat structures as loads. He stated that while structures may have weight, which is a load and may support other loads that transfer to the soil through foundations, that does not mean a structure such as a retaining wall is referred to as a load in an engineering document.
- [179] With respect to the wall in issue, he rejected the idea that the reason for the wall's collapse was the wall being underbuilt. He explained that the wall stood for more than 30 years, withstanding the elements before the incident. He disagreed with Mr. Weiss that the wall was in progressive overturning mode. I note that both Dr. Hamidi and Mr. Weiss agreed that the wall stood in a stable condition until the trench was excavated in front of it.

- [180] Regarding the actions of a reasonable foreperson in these circumstances, Dr. Hamidi stated in his supplemental report that when faced with a geotechnical engineer's instruction that does not account for the presence of adjacent structures in the planned trench area, the supervisor should stop work and implement safety measures. Dr. Hamidi suggested that the supervisor should contact the geotechnical engineer to point out the oversight and request an updated instruction that specifically considers the adjacent structures. This clarified guidance must include the steps needed to secure the excavation for safe entry and ongoing work by the crew.
- [181] If the original engineer does not provide clear written instructions, the supervisor should consult another qualified, registered professional engineer. That engineer should assess the site conditions and offer specific, actionable directions to ensure safety around the existing structure. Finally, the supervisor should record the issue and all steps taken to address it, including written communications with the geotechnical engineer and other involved professionals. Maintaining documentation ensures accountability and provides a reference for future project safety and compliance. In this case, neither Mr. Green nor any other supervisor took such action for this Project.
- [182] Dr. Hamidi's supplemental report also examined the standard of care for interpreting Condition 2 of the October 2 Certificate's geotechnical instructions. He stated that a reasonable employer, supervisor, or foreman would review the engineer's trenching instructions with the engineer before excavation to ensure all requirements are clear and actionable. If they encounter ambiguous or incomplete guidance--especially regarding adjacent structures--they should consider the instruction inadequate and promptly take corrective action. These actions include stopping work, securing the excavation, requesting an updated directive, engaging another qualified engineer if needed, and documenting all communications and steps taken.
- [183] Dr. Hamidi addressed the importance of having written instructions before excavation along adjacent structures in terms of regulatory compliance, ensuring safety, utilizing the specialized geotechnical engineer's knowledge to perform safe work, the tailored site-specific nature of the geotechnical engineer's instructions to ensure safe and effective work, and preventing damage to the adjacent structures.
- [184] Dr. Hamidi stated that the geotechnical engineer's instructions should always be given in writing to establish an official record. Verbal instructions are not acceptable and do not comply with the OHSR.
- [185] He testified that the written instructions should be comprehensive, clear, without ambiguity, specific to the job site, and compliant with the regulations. He underscored the importance of halting work until the supervisor receives such clear written instructions.

[186] In Dr. Hamidi's view, employers and supervisors must put worker safety first by asking the geotechnical engineer to put any supplemental verbal instructions in writing. They should stop work in the affected area until they have those written instructions or confirm that existing documentation already covers the change. Having written guidance creates a clear record and prevents misunderstandings.

19) Andrew Kidd, WorkSafeBC Expert

[187] Andrew Kidd is the WorkSafeBC Director of Prevention Field Services, appointed on October 15, 2024. He has substantial experience in construction, excavation, and worksite safety. The Crown called Mr. Kidd to explain the standard of care that applied to supervisors engaged in construction and excavation. In particular, Mr. Kidd described the industry standard of care and how supervisors of construction excavation should apply the OHSR in practice. Mr. Kidd's qualifications to give opinion evidence on occupational health and safety issues were generally not challenged, and I accepted his qualifications in these areas, except where he occasionally strayed into legal opinion.

[188] Mr. Kidd adopted the content of three reports. Each report was written in the form of questions, which he answered in writing. All related to the standard of care to be followed in excavation construction by employers, supervisors, and qualified registered professionals.

[189] Mr. Kidd's evidence included the following opinions summarized from his first report:

- 1) The standard of safety protocols for a reasonable person in the role of a supervisor on an excavation site entails proactive risk assessment.
- 2) The scope of safe excavation supervision includes supervisory responsibility; identification of hazards; risk assessment; proactive assessments of high-risk conditions; and proactive use of control measures for safety.
- 3) Excavation work near structures must follow written instructions from a qualified professional, and identifying hazards requires a risk assessment. The assessment and control measures must be documented, available on site, and certified. Supervisors are responsible for ensuring these documents are accessible and adequate, and for halting work if necessary to prevent risks.
- 4) The standard of care applicable to supervisors requires them to be fully aware of regulatory requirements and potential hazards related to excavation work. They should know that if a structure or improvement is located within a distance equal to or less than the depth of the excavation, it is considered adjacent and poses a risk.
- 5) The duties of a reasonable person in the role of a supervisor on an excavation site relate to a construction supervisor's or employer's duty, primarily defined by the WCA, the OHSR, and the associated guidelines and policies that support their implementation.

- 6) An employer or supervisor on an excavation site should anticipate hazards.
 - 7) Excavations over four feet deep are high risk for danger or hazards. A worker inside an excavation deeper than four feet, and within a horizontal distance equal to or less than its depth, is in a high-risk situation if the excavation is not sloped correctly, shored, or supported according to engineering standards. This scenario is officially classified as a designated high-risk violation, previously known informally as one of the "eleven deadly sins" in safety regulations.
 - 8) The proximity of adjacent structures or an adjacent improvement to an excavation is regulated.
 - 9) "Structure," "improvement," and "adjacent" are significant concepts in excavation and construction that enable reasonably informed supervisors and other participants to assess the proximity and potential impact during excavation or construction planning.
 - 10) A supervisor of an excavation project should be certain he has instructions on how to dig near adjacent structures when there are workers in a trench dug within a metre of an adjacent structure, such as a retaining wall.
 - 11) Supervisors must implement risk control because an adjacent structure can become an adjacent hazard, especially if the trench is deeper than four feet.
 - 12) A supervisor in the same excavation project should stop work if a worker points out to them that the adjacent structure or improvement, such as a retaining wall, has a crack in the wall (a cold joint) which has just separated.
- [190] In Mr. Kidd's second report, he answered a series of six questions. His answers, inter alia, included the following:
- 1) An employer-supervisor should assess the report and stop work when presented with a geotechnical engineer's report that fails to identify the presence of structures within the anticipated trench area.
 - 2) A reasonable supervisor should recognize the trench edge as the excavation's uppermost lip--the closest point to any potential hazard--and therefore ensure that any vibration source, load, or spoil pile is placed at a distance beyond that nearest edge to meet safety limitations. Section 20.90 of the OHSR prescribes that transient loads be kept two feet or 0.6 metres away or setback from the trench edge. Mr. Kidd interpreted this requirement as an instruction to avoid putting things such as machinery, transient loads, and other transient things which cause vibrations near the trench edge, not a reference to static structures.
 - 3) Only transient loads are captured in a geotechnical engineering instruction, such as Mr. Yip's Condition 2 regarding the required distance from the excavation edge to a nearby structure.

- 4) Written instructions from a geotechnical engineer are required before excavating near adjacent structures.
- 5) A reasonable employer-supervisor who receives supplemental verbal (i.e., not written) instructions from the geotechnical engineer related to the report should get it in writing.
- 6) A professional engineer can provide clear instructions to an employer-supervisor on how to dig next to an adjacent structure.

[191] In Mr. Kidd's third supplemental report, he provided inter alia the following opinions:

- 1) The October 2 Certificate was inadequate in that it provided no instructions on how to safely dig next to the adjacent structures or improvements.
 - 2) Supervisors need to ensure instructions prepared by a qualified registered professional are "fit for purpose." Yet the October 2 Certificate provides no explicit trench location or a "planned view" showing the trench's proximity to property lines and structures. This is a serious impediment for how to dig. He added that from the standpoint of a board safety officer, the instructions as they stand do not satisfy excavation regulations.
 - 3) Contractors should begin every project by systematically identifying potential hazards and assessing which risks fall within their capacity to control before consulting an engineer. Employers and supervisors must understand the nature of their work to recognize and address hazards effectively. In this regard, he pointed to ss. 20.78 and 20.80 of the OHSR.
- 20) The Cause of Death of the Deceased, Mr. Jeffrey Caron

[192] Dr. Carol Lee, an expert in forensic pathology, testified regarding the post-mortem examination of Jeffrey Caron. She found that Mr. Caron was healthy at the time of his death, with no significant disease or pre-existing conditions. Dr. Lee found that he died as a result of multiple blunt force injuries, consistent with trauma from a heavy object, specifically, the wall that fell on him. The injuries included a fatal transection of the aorta, severe brain trauma, including bleeding around the brainstem, multiple rib fractures, and significant internal bleeding. Dr. Lee concluded that the cause of death was multiple blunt force traumas, with either the brain or aorta injuries being independently fatal. Her Report of Postmortem Examination was admitted into evidence.

[193] I find that Mr. Caron's death was the direct result of the wall that collapsed onto him, leading to the traumatic and fatal injuries detailed by Dr. Lee.

21) The Defence Evidence

[194] Three witnesses were called by the accused. Like the other workers involved, all three were devastated by this tragedy. No malice can be ascribed to any of them.

a) The Accused, David Green

- [195] Mr. Green was the foreman for the Edinburgh laneway project. He has considerable experience in the construction industry. He started out as a pipelayer, doing that job for approximately 10 years. He then graduated to working as a foreman. He obtained a job at J. Cote in 1995-1996. Initially, he returned to work as a pipelayer for five years. He then became a foreman. Almost all of his training was on-the-job training. He had received no formal training in trench-specific hazard assessment.
- [196] I accept that Mr. Green was a hard worker. He arrived at the job site by 6:00 a.m. every morning. He reviewed plans and equipment, checked the certification, and monitored changing weather conditions.
- [197] Mr. Green testified that safety was a top priority. Yet he did not proactively assess the retaining wall before its collapse and did not have a safety plan beyond calling 911 in the event of an emergency. He testified that he had a disassembled shoring cage with spreader bars on each end at the start of the Edinburgh Laneway, but they did not use it.
- [198] Although Mr. Green maintained that he had an informal "safety meeting" every morning, I find that this was not the case on this jobsite. His evidence about the safety aspect of his meetings was vague. He referred to having "chit chats" rather than formal meetings every day, a term that undermines the idea that safety protocols were effectively reviewed in such meetings. He described the content of such meetings as what we're going to do on the site and how we're going to do it safely. He was unable to be specific about any protocols, procedures, or discussions he had regarding hazard identification or accident prevention. He made no notes to verify the content of such meetings at the Edinburgh Laneway Project. I find that his evidence on this point was obviously exaggerated and self-serving.
- [199] Mr. Green testified, and I accept, that he did not have any formal training as a junior foreman in reading geotechnical reports. He usually reviewed them with Mr. Cote or Mr. Trigg and would share his interpretation of what the report meant. He believed he understood the reports he reviewed.
- [200] Mr. Green said that he relied on the October 2 Certificate issued by Mr. Yip. Like Mr. Cote, Mr. Green asserted that he understood the engineering certificate to require a 0.6 metre setback from "heavy loads" adjacent to the excavation and said that, based on his past work with Mr. Yip, he interpreted this term broadly to include retaining walls and similar structures.
- [201] However, Mr. Green never had a specific conversation with Mr. Yip to confirm what "load" meant in this particular context. No part of the certificate defined this term or referred explicitly to the retaining wall that collapsed.
- [202] Although Mr. Green testified that he was "99%" sure he walked the laneway with Mr. Yip to a point just past where the retaining wall collapsed, I reject his evidence on this point. Mr. Green did not appear to have a specific recollection of walking the laneway with Mr. Yip, and the memory that he did appeared to be reconstructed after the fact. In Mr. Yip's mind,

he was only certifying the initial trench as safe and would have had no reason to walk the laneway. As well, if they had walked the laneway, one would have expected Mr. Yip's report to be more specific about adjacent structures, when in fact it made no mention of adjacent structures.

- [203] Mr. Green took the position that the wall that ultimately failed was poorly constructed and that he could not have anticipated its collapse. He acknowledged, however, that he did not know who had built the wall and did not make any inquiries to determine whether it had been engineered or constructed to standard. His assumption that the wall was sufficiently stable rested entirely on its appearance, his failure to notice the significance of the gaps and the lack of reinforcement, and the fact that it had not previously failed.
- [204] Mr. Green testified that the alignment of the storm line in the trench was moved closer to the sanitary line, approximately six to eight inches further away from the wall. He indicated that he discussed this with Mr. Cote, though he did not have a specific memory of that conversation. However, Mr. Cote was unable to confirm that such a shift occurred. The alleged realignment was not put to any of the Crown's witnesses during cross-examination. Nor is it supported by field documentation or survey records. I must reject this evidence, but I find in any case that this adjustment of the alignment, if it occurred, had no significant effect on the ultimate position of the trench.

b) Chad Allen

- [205] Chad Allen was a junior foreman who worked for J. Cote on the Edinburgh Lane Project in 2012. He started working there in 2009. He was promoted to a general superintendent five years ago. He was in charge of the second crew working on the laneway behind Mr. Green's crew.
- [206] Mr. Allen acknowledged that many of the now-standard safety practices--such as daily trench assessment forms, signed pre-task checklists, and proper documentation of toolbox meetings--were implemented only after the fatal incident. Before that, safety measures were largely verbal, undocumented, and reliant on field experience.
- [207] Mr. Allen's recollection was vague on some points, such as whether he walked the laneway with Mr. Green and Mr. Yip before or after the wall collapse.
- [208] Mr. Allen signed an October 2012 internal incident investigation report, though he denied having contributed to the investigation. He alleged that the company and WorkSafeBC had instructed him on what to include in that document.
- [209] The Crown points out that Mr. Allen conceded he had, on multiple occasions, ridden a backhoe without a seatbelt or safety belt, in violation of safety regulations. While this may have been inappropriate, I disagree with the Crown that it is causally significant in supporting a broader culture of habitual risk-taking.

- [210] Like Mr. Green and Mr. Cote, Mr. Allen relied entirely on the October 2 Certificate to justify the two-foot setback used at the Edinburgh Laneway excavation site. Mr. Allen stated that he did not see it as a red flag because he trusted the engineer. Like Mr. Green and Mr. Cote, the same two-foot distance was applied to all structures along the laneway.
- c) Jamie Cote, the Principal of J. Cote
- [211] James Cote is the owner and sole director of J. Cote. & Sons Excavating Ltd. He testified in the company's defence.
- [212] Mr. Cote began working for his father's company at approximately 14 years old, during summers and weekends while still in school. At some point, he accompanied his father to Vancouver Island, where he briefly worked for another company, installing sewer and water service connections.
- [213] Mr. Cote then brought these skills back to J. Cote, where they later became part of the company's operations.
- [214] Following graduation, he remained continuously employed by the family business and, over time, assumed ownership of the company. He initially grew the business alongside his brother-in-law and father, though the former ceased involvement more than two decades ago, and the latter gradually retired.
- [215] By October 2012, the time of the fatal incident, Mr. Cote was the sole person in charge of the company's operations and management. He stated that he had likely been in that position for about ten years prior to the wall collapse. He was not only the owner and director in title, but the de facto source of all managerial and operational decision-making. In his role, he was responsible for everything from project oversight to safety compliance.
- [216] Mr. Cote had never received any formal safety orientation when he began working at the company. Instead, he described growing up in the business, acquiring his knowledge through hands-on experience and the continuity of practice. In his view, those methods had "always worked well."
- [217] Mr. Cote acknowledged that excavation and trenching work are inherently dangerous and leave very little room for error when it comes to worker safety. He agreed that this type of work is classified as high-risk by both industry standards and WorkSafeBC, and that J. Cote fell within that high-risk category. Mr. Cote further accepted that working around heavy machinery demands constant vigilance from all workers on site, regardless of whether trenching is underway at that moment.

- [218] Mr. Cote acknowledged that his company, as the prime contractor, bore sole responsibility for safety on the Edinburgh Laneway site. He testified that he had been familiar with the Master Municipal Construction Documents (MMCD) since their inception and confirmed that by 2012, he had worked under at least three versions of that framework. He confirmed that s. 4.2.1 of the MMCD meant that J. Cote alone was responsible for all aspects of safety on the project.
- [219] Mr. Cote understood the word "heavy load" in Mr. Yip's report as something that couldn't be carried by a person. He understood that "load" was an intentionally broad term encompassing all external forces, including those from adjacent structures. He thought that part of Mr. Yip's retainer was to deal with adjacent structures. Mr. Cote said that his interpretation of the instructions was developed from his past dealings with Mr. Yip and his familiarity with how Mr. Yip had used the word "load" in past reports.
- [220] Mr. Cote claimed that Mr. Yip had explained this broad meaning to him, though I reject Mr. Cote's testimony on this point because it was denied by Mr. Yip, inconsistent with Mr. Yip's understanding, and makes little sense from an engineering or regulatory point of view.
- [221] Mr. Cote initially claimed to have reviewed many engineering reports, both before and after 2012, and stated that the term "load" was used by other engineers in their reports to refer to adjacent structures. He then changed his answer to indicate that he was not sure if other engineers used the word to refer to structures. He later stated that he could not recall discussing the term with any engineer other than Mr. Yip and did not recall seeing the word "load" used in a report from another engineer.
- [222] Mr. Cote stated that he understood the October 2 Certificate as indicating that they had to stay two feet from the toe of the wall. However, he conceded that the certificate did not specify from where the two-foot distance should be measured (whether from the face, toe, or top of a structure). He could not explain why the same two-foot setback should be applied uniformly to every structure on the site, regardless of the structure's size, material, or configuration.
- [223] He insisted that the engineer's use of the word "load" covered all these elements, even though the report made no reference to individual hazards or measurement points.
- [224] I find that Mr. Cote's understanding of the term "heavy load" did not accord with Mr. Yip's understanding.
- [225] Mr. Cote did not request Mr. Yip to confirm whether the adjacent structures at the Edinburgh Laneway Project site had been specifically assessed.
- [226] Mr. Cote testified regarding the company's internal incident investigation report, which was submitted to WorkSafeBC following the fatal incident. He confirmed that the report had been prepared by site superintendent Greg Trigg.

LEGAL PRINCIPLES

1) The Criminal Negligence-Based Offences (Counts 1 and 2)

[227] On count 1, the accused are charged with criminal negligence causing death, contrary to s. 220(b) of the Criminal Code, which provides as follows:

220 Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable

(b) in any other case, to imprisonment for life.

[228] On count 2, the accused are charged under s. 221(a) of the Criminal Code, which provides as follows:

221 Every person who by criminal negligence causes bodily harm to another person is guilty of

(a) an indictable offence and liable to imprisonment for a term of not more than 10 years; []

[229] Criminal negligence is defined in s. 219 of the Criminal Code as follows:

219 (1) Every one is criminally negligent who

(a) in doing anything, or

(b) in omitting to do anything that it is his duty to do,

shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section, duty means a duty imposed by law.

[230] Section 217.1 of the Criminal Code imposes a duty upon everyone "who has the authority to direct how another person does work or performs a task to take reasonable steps to prevent bodily harm to that person or any other person arising from that work or task". Unlike a regulatory offence, the burden is not on the accused to establish due diligence or an absence of fault. The burden is on the Crown to prove the elements of the offence beyond a reasonable doubt.

[231] To obtain a conviction for criminal negligence causing death or criminal negligence causing bodily harm, the Crown must prove the following elements beyond a reasonable doubt.

a) A Legal Duty

[232] The accused must have had a duty imposed by law, either under statute (e.g., s. 217.1) or under common law. Merely breaching a statutory duty is not, by itself, enough to establish criminal negligence: *R. v. Lilgert*, 2014 BCCA 493 at para. 40.

b) The Actus Reus and Causation

[233] The actus reus of criminal negligence causing death requires that the accused undertook an act--or omitted to do anything that it was his or her legal duty to do--and that the act or omission caused someone's death: *R. v. Javanmardi*, 2019 SCC 54 at para. 19.

- [234] As part of the actus reus, the Crown must prove that the accused's act or omission caused the harm: *R. v. Bouvette*, 2023 BCCA 152 at para. 123. The accused's conduct must be a significant contributing cause of the victim's bodily harm or death: *R. v. Maybin*, 2012 SCC 24 at paras. 28, 44, and 60; *R. v. Nette*, 2001 SCC 78.
- [235] The cause must be both the factual cause and the legal cause of the harm in question. Factual causation asks what actually caused the death/bodily harm, or whether the accused's actions were a "but for" cause of the consequence. The accused's actions need not be the most direct and immediate cause, nor even the most significant cause, so long as they were a significant contributing cause.
- [236] Legal causation requires that there was no intervening cause that broke the chain of causation between the actions of the accused and the resulting harm. While reasonable foreseeability and an independent action are two analytical aids for assessing legal causation, they are not determinative: *Maybin* at paras. 15-16.
- [237] Causation is one of the overlapping elements of unlawful act manslaughter and criminal negligence causing death: *Javanmardi* at paras. 17, 19, and 25.
- c) The Mens Rea - Marked and Substantial Departure
- [238] The fault element is that the accused's act or omission "shows wanton or reckless disregard for the lives or safety of other persons": *Javanmardi* at para. 20.
- [239] Neither "wanton" nor "reckless" is defined in the Criminal Code, though the phrase "wanton or reckless" clearly refers to a high degree of negligence. The term "wanton" means "heedlessly" or demonstrating an unrestrained disregard for consequences: *R. v. Waite* (1996), 28 C.C.C. (3d) 326 (Ont. C.A.); *Regina v. Pinske* 1988 CanLII 3118 (BC CA), 6 M.V.R. (2d) 19 (B.C.C.A.) at 33.
- [240] For some negligence-based offences, such as dangerous driving, a "marked" departure satisfies the fault element. In the context of criminal negligence causing death, however, the requisite degree of departure has been described as an elevated one. Criminal negligence requires a marked and substantial departure from the conduct of a reasonably prudent person in circumstances in which the accused either recognized and ran an obvious and serious risk or, alternatively, gave no thought to that risk: *R. v. A.D.H.*, 2013 SCC 28 at para. 61. The distinction is a matter of the degree to which the accused's conduct departs from that of a reasonable person in the circumstances: *Javanmardi* at paras. 21-22.
- [241] In *R. v. Lilgert*, 2014 BCCA 493 at para. 43, the Court approved the following instruction on the fault requirement, which read as follows:
- [43] []

To prove that NOA [name of accused] showed a wanton or reckless disregard for the lives or safety of others, the Crown does not have to establish that NOA meant to kill or seriously harm NOC [name of complainant], or anybody else. Rather, the Crown must prove beyond a reasonable doubt:

1. that NOA's conduct showed a marked and substantial departure from the conduct of a reasonable person in the circumstances; and
2. that a reasonable person in the same circumstances would have foreseen that this conduct posed a risk of bodily harm. "Bodily harm" is any hurt or injury that interferes with a person's health or comfort and is more than brief or minor.

In deciding what a reasonable person would have done or foreseen, you must not take into account NOA's individual characteristics or experiences.

[Canadian Judicial Council, IV. Criminal Negligence Causing Death, Offence 220 at para. 5]

[242] The Court noted that this instruction mirrored the analysis in *R. v. J.F.*, 2008 SCC 60 at paras. 9 and 11, and that a similar instruction was approved in *R. v. Kerr*, 2013 BCCA 506 at para. 37.

[243] The accused's state of mind is relevant to an objective assessment of the conduct in issue: *R. v. Beatty*, 2008 SCC 5 at paras. 43, 47 and 49; *Lilgert* at para. 50.

[244] In *J.F.*, the Court confirmed that the offence of criminal negligence causing death imposes a modified objective standard of fault--the objective "reasonable person" standard. The modified objective test means that the trier of fact considers both the objective standard of a reasonable person and the circumstances known to the accused at the time: *R. v. Tutton*, 1989 CanLII 103 (SCC), [1989] 1 S.C.R. 1392; *R. v. Hundal*, [1993] 1 S.C.R. 867, 1993 CanLII 120.

[245] Greater care may be expected of the reasonable person depending on the nature and circumstances of the activity. Thus, while the standard is not determined by the accused's personal characteristics, it is informed by the nature of the activity and the circumstances surrounding the accused's failure to take the requisite care: *Javanmardi* at paras. 37-38; *R. v. Creighton*, [1993] 3 S.C.R. 3, CanLII 61 (S.C.C.) at p. 72; *R. v. Dittmer*, 2025 BCCA 260 at paras. 16-27.

2) The Unlawful Act Manslaughter Offence (Count 3)

[246] On count 3, Mr. Green alone is charged with unlawful act manslaughter contrary to s. 222(5) (a) of the Criminal Code, which provides as follows:

222 (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

[]

- (5) A person commits culpable homicide when he causes the death of a human being,
- (a) by means of an unlawful act;

[247] Unlawful act manslaughter referred to in s. 222(5)(a) of the Criminal Code is one classification of the offence of manslaughter. The structure of the offence depends on a predicate offence of an unlawful act, coupled with a homicide.

[248] In addition to the actus reus and mens rea associated with the underlying act, there must exist a reasonable foreseeability of the risk of bodily harm. While s. 222(5)(a) does not expressly require foreseeable bodily harm, it has been so interpreted. The unlawful act must be objectively dangerous, in that it is likely to injure another person. Foreseeability of death, however, is not required: Creighton; R. v. DeSousa, 1992 CanLII 80 (SCC), [1992] 2 S.C.R. 944.

[249] Thus, the Crown must prove the following elements of the offence of unlawful act manslaughter:

- 1) The actus reus of the offence, that the accused committed an unlawful act in the form of the predicate offence.
- 2) The unlawful act caused death.
- 3) The fault element, being the objective foreseeability of the risk of bodily harm which is neither trivial nor transitory, coupled with the fault element for the predicate offence (the dangerous act). Where the predicate offence is one of strict liability, the fault element for that offence must be read as a marked departure from the standard expected of a reasonable person in the circumstances.

Javanmardi at paras. 25-31; R. v. Barton, 2019 SCC 33 at para. 140.

[250] In R. v. Fournier, 2018 QCCQ 1071 [Fournier C.Q.] and R. v. Fournier, 2016 QCCS 5456 [Fournier C.S.], a case that dealt with the failure to shore the walls of a trench contrary to construction regulations, the issue was whether a breach of Quebec's Safety Code for the Construction Industry--a strict liability regulatory offence--could serve as the predicate "unlawful act" for the purposes of s. 222(5)(a).

[251] In Fournier C.S., Cournoyer J. confirmed that it could, provided two conditions were met: first, that the offence was objectively dangerous, and second, that the Crown proved beyond a reasonable doubt that the accused's conduct represented a marked departure from the standard of care of a reasonable person: at para. 80. By including this requirement, this approach "reads up" the fault element of strict liability offences and thus avoids the imposition of criminal liability on the basis of mere civil negligence: see also, Javanmardi at para. 64-65 ("To ensure a minimum degree of moral blameworthiness, the Crown must therefore establish a negligent state of mind corresponding to a "marked departure").

[252] As recognized in *Javanmardi*, there is a degree of conceptual overlap between unlawful act manslaughter and criminal negligence causing death. The distinction lies in the fault standard. Unlawful act manslaughter, when grounded in a strict liability predicate offence, requires proof of a marked departure from the conduct of a reasonable person. By contrast, criminal negligence causing death requires proof of a marked and substantial departure from the conduct of a reasonable person in the accused's circumstances.

[253] As to the relevance of subjective factors, the Court in *R. v. Dittmer*, 2025 BCCA 260 at para. 27, held that while the objective fault component of the offence of manslaughter is premised on uniform societal standards of behaviour and does not permit consideration of subjective intent or knowledge, it is sufficiently contextualized to permit consideration of all factors that might have informed or affected the care exercised by a reasonable person.

3) Corporate Liability

[254] In 2004, Parliament passed Bill C-45, known as the Westray Bill, which introduced key changes to the Criminal Code. These amendments stemmed from recommendations in the public inquiry of the 1992 Westray Mine disaster in Nova Scotia, where 26 miners were killed in an underground explosion caused by preventable safety violations: Justice K. Peter Richard, *The Westray Story - A predictable Path to Disaster: Report of the Commission of Inquiry into the Westray Mine Tragedy*, December 1, 1997.

[255] The Westray amendments included the addition of s. 217.1 of the Criminal Code, which, as noted above, imposes a legal duty on those who direct work to take reasonable steps to prevent bodily harm:

217.1 Every one who undertakes, or has the authority, to direct how another person does work or performs a task is under a legal duty to take reasonable steps to prevent bodily harm to that person, or any other person, arising from that work or task.

[256] The amendments also added s. 22.1, which outlines how organizations can be held criminally liable for negligence. Together, these provisions create a legal framework for corporate liability when their conduct, or inaction, demonstrates a certain disregard for the lives or safety of others.

[257] Section 22.1 deals with rules for attributing negligence-based offences to organizations. The section includes joint liability language that may attract corporate liability for the combined actions of multiple representatives and senior officers. It provides as follows:

Offences of negligence - organizations

22.1 In respect of an offence that requires the prosecution to prove negligence, an organization is a party to the offence if

- (a) acting within the scope of their authority
- (i) one of its representatives is a party to the offence, or

(ii) two or more of its representatives engage in conduct, whether by act or omission, such that, if it had been the conduct of only one representative, that representative would have been a party to the offence; and

(b) the senior officer who is responsible for the aspect of the organization's activities that is relevant to the offence departs -- or the senior officers, collectively, depart -- markedly from the standard of care that, in the circumstances, could reasonably be expected to prevent a representative of the organization from being a party to the offence.

[258] While s. 22.1(b) refers to "markedly" departing from the standard of care, in the present context, I would apply a standard of "marked and substantial" departure from the requisite standard of care because the predicate offence of criminal negligence causing bodily harm or death requires an elevated degree of fault.

[259] Representative and senior officer are defined in s. 2 of the Criminal Code as follows:

"representative", in respect of an organization, means a director, partner, employee, member, agent or contractor of the organization.

"senior officer" means a representative who plays an important role in the establishment of an organization's policies or is responsible for managing an important aspect of the organization's activities and, in the case of a body corporate, includes a director, its chief executive officer and its chief financial officer;

[260] The presence of corporate criminal liability for criminal negligence in the Criminal Code is not intended to duplicate, replace, or interfere with provincial health and safety legislation. Rather, it is intended to provide additional deterrence for morally blameworthy conduct that amounts to a wanton and reckless disregard for the lives or safety of others: *R. v. Metron Construction Corporation*, 2013 ONCA 541 at para. 81 quoting Minister of Justice, "Government Response to the Fifteenth Report of the Standing Committee on Justice and Human Rights", Sessional Paper No. 8512-372-178 (2002).

[261] These provisions have been referred to in some, though not many, cases involving industrial accidents: *R. v. Stave Lake Quarries Inc.*, 2016 BCPC 377 (sentencing of a corporation convicted of criminal negligence causing death involving a rock hauler that rolled over and crushed a worker where the company's guilt was founded upon the combined lapses in its hiring, training and supervision of the worker); *R. v. Metron Construction Corporation*, 2012 O.N.C.J. 506, sentence appeal allowed 2013 ONCA 541 (sentencing of a construction company for criminal negligence causing death involving the collapse of a swing stage used in the restoration of concrete balconies on two high rise buildings); *R. v. Scrocca*, [2010] Q.J. No. 9605 (a conviction for criminal negligence causing death involving a backhoe, in poor mechanical condition, that rolled down a slope and killed a worker after the brakes failed); *R. v. Transpavé*, 2008 QCCQ 1598 (conviction for criminal negligence causing death for a worker killed by a collapsing pile of stones on a production line in a concrete slab and block manufacturing plant).

- [262] In *Fournier C.Q.*, an excavation contractor was found guilty of criminal negligence causing death and manslaughter, with a conditional stay on the first charge. An earlier judicial review decision in the same case upheld the Crown's ability to proceed on a charge of criminal negligence supported by a strict liability predicate offence: *Fournier C.S.* The charges pertained to an incident where the walls of an eight-foot trench with vertical sides, dug to replace a sewer pipe, collapsed. The judicial review court in Quebec held that a manslaughter charge could be based on a strict liability occupational health and safety offence. The Court explained that the trench's geometry--its width, depth, the 90-degree angles of the walls, the spoil deposits on both sides at insufficient distances as per current regulations, and especially the fact that the excavation and connection work had to be done manually at a depth of eight feet within a 42-inch-wide space--made the risk of bodily injury obvious and apparent to a reasonable observer in similar circumstances: para. 120.
- [263] The *Westray* amendments were also considered in *CFG Construction Inc. v. R.*, 2023 QCCA 1032, where the Quebec Court of Appeal upheld a conviction for criminal negligence causing death against a construction company whose improperly maintained truck led to a fatal accident. In that case, the Court held that determining corporate criminal liability can involve more than examining an isolated incident. Rather, it can include assessing the company's overall approach to safety, including whether it consistently neglected its duty to prevent harm through proper oversight, training, and maintenance.

4) Legal Scheme Governing Excavation Work in B.C.

- [264] Excavation work on construction sites is highly regulated in British Columbia. The following excerpts from the WCA and regulations thereto are taken from the relevant sections in effect at the time of the wall collapse in 2012.

a) The WCA

- [265] The WCA, Part 3 - Occupational Health and Safety, set out the purposes of this part of the Act as follows:

107 (1) The purpose of this Part is to benefit all citizens of British Columbia by promoting occupational health and safety and protecting workers and other persons present at workplaces from work related risks to their health and safety.

(2) Without limiting subsection (1), the specific purposes of this Part are

- (a) to promote a culture of commitment on the part of employers and workers to a high standard of occupational health and safety,
- (b) to prevent work related accidents, injuries and illnesses,
- (c) to encourage the education of employers, workers and others regarding occupational health and safety,

- (d) to ensure an occupational environment that provides for the health and safety of workers and others,
- (e) to ensure that employers, workers and others who are in a position to affect the occupational health and safety of workers share that responsibility to the extent of each party's authority and ability to do so,
- (f) to foster cooperative and consultative relationships between employers, workers and others regarding occupational health and safety, and to promote worker participation in occupational health and safety programs and occupational health and safety processes, and
- (g) to minimize the social and economic costs of work related accidents, injuries and illnesses, in order to enhance the quality of life for British Columbians and the competitiveness of British Columbia in the Canadian and world economies.

[Emphasis added.]

[266] Under s. 108(1)(b), this Part applies to every employer and worker whose occupational health and safety are ordinarily within the jurisdiction of the provincial government.

[267] Section 115 dealt with the general duties of employers and provided as follows:

115 (1) Every employer must

- (a) ensure the health and safety of
 - (i) all workers working for that employer, and
 - (ii) any other workers present at a workplace at which that employer's work is being carried out, and
 - (b) comply with this Part, the regulations and any applicable orders.
- (2) Without limiting subsection (1), an employer must
- (a) remedy any workplace conditions that are hazardous to the health or safety of the employer's workers,
 - (b) ensure that the employer's workers
 - (i) are made aware of all known or reasonably foreseeable health or safety hazards to which they are likely to be exposed by their work,
 - (ii) comply with this Part, the regulations and any applicable orders, and
 - (iii) are made aware of their rights and duties under this Part and the regulations,
 - (c) establish occupational health and safety policies and programs in accordance with the regulations,

- (d) provide and maintain in good condition protective equipment, devices and clothing as required by regulation and ensure that these are used by the employer's workers,
- (e) provide to the employer's workers the information, instruction, training and supervision necessary to ensure the health and safety of those workers in carrying out their work and to ensure the health and safety of other workers at the workplace,
- (f) make a copy of this Act and the regulations readily available for review by the employer's workers and, at each workplace where workers of the employer are regularly employed, post and keep posted a notice advising where the copy is available for review,
- (g) consult and cooperate with the joint committees and worker health and safety representatives for workplaces of the employer, and
- (h) cooperate with the Board, officers of the Board and any other person carrying out a duty under this Part or the regulations.

[268] Section 117 set out the general duties of supervisors and provided as follows:

117 (1) Every supervisor must

- (a) ensure the health and safety of all workers under the direct supervision of the supervisor,
- (b) be knowledgeable about this Part and those regulations applicable to the work being supervised, and
- (c) comply with this Part, the regulations and any applicable orders.

(2) Without limiting subsection (1), a supervisor must

- (a) ensure that the workers under his or her direct supervision
 - (i) are made aware of all known or reasonably foreseeable health or safety hazards in the area where they work, and
- (ii) comply with this Part, the regulations and any applicable orders,
 - (b) consult and cooperate with the joint committee or worker health and safety representative for the workplace, and
 - (c) cooperate with the Board, officers of the Board and any other person carrying out a duty under this Part or the regulations.

[Emphasis added.]

[269] Section 118(1)(a) sets out the definition and duties of a prime-contractor in relation to a multiple-employer workplace:

118 (1) In this section:

"multiple-employer workplace" means a workplace where workers of 2 or more employers are working at the same time;

"prime contractor" means, in relation to a multiple-employer workplace,

- (a) the directing contractor, employer or other person who enters into a written agreement with the owner of that workplace to be the prime contractor for the purposes of this Part, or
 - (b) if there is no agreement referred to in paragraph (a), the owner of the workplace.
- (2) The prime contractor of a multiple-employer workplace must
- (a) ensure that the activities of employers, workers and other persons at the workplace relating to occupational health and safety are coordinated, and
 - (b) do everything that is reasonably practicable to establish and maintain a system or process that will ensure compliance with this Part and the regulations in respect of the workplace.
- (3) Each employer of workers at a multiple-employer workplace must give to the prime contractor the name of the person the employer has designated to supervise the employer's workers at that workplace.

[270] Employer is defined in s. 106 of the WCA as follows:

"employer" means

- (a) an employer as defined in section 1,
- (b) a person who is deemed to be an employer under Part 1 or the regulations under that Part, and
- (c) the owner and the master of a fishing vessel for which there is a crew to whom Part 1 applies as if the crew were workers,

but does not include a person exempted from the application of this Part by order of the Board;

[271] The term supervisor is not defined in the WCA.

- b) The Occupational Health and Safety Regulation ("OHSR")

[272] The OHSR applies to every employee and worker whose occupational health and safety are ordinarily within the jurisdiction of the government of British Columbia: s. 108(1)(b). At the relevant time, the OHSR provided the following general duty for work:

General duty

2.2 Despite the absence of a specific requirement, all work must be carried out without undue risk of injury or occupational disease to any person.

[273] The OHSR defined "hazard" and "hazard area" at the outset of the OHSR as follows:

"hazard" means a thing or condition that may expose a person to a risk of injury or occupational disease;

"hazard area" means an area in a workplace where a hazard exists, or is created, due to a condition in the area or the activities conducted in it;

[274] The OHSR also provided the following work standards in Part 20 - Construction, Excavation and Demolition:

Work standards

20.78 (1) Subject to this section, excavation work must be done in accordance with the written instructions of a qualified registered professional if

- (a) the excavation is more than 6 m (20 ft.) deep,
 - (b) an improvement or structure is adjacent to the excavation,
 - (c) the excavation is subject to vibration or hydrostatic pressure likely to result in ground movement hazardous to workers, or
 - (d) the ground slopes away from the edge of the excavation at an angle steeper than a ratio of 3 horizontal to 1 vertical.
- (2) Despite subsection (1), excavation work described in that subsection must be done in accordance with the written instructions of a professional engineer if the excavation requires or uses support structures.
- (3) The written instructions required by this section must
- (a) be certified by the qualified registered professional concerned,
 - (b) be available at the site, and
 - (c) specify the support and sloping requirements, and the subsurface conditions expected to be encountered.

[Emphasis added.]

[275] Section 20.1 defines certain key terms as follows:

"adjacent to an excavation" means within a distance less than or equal to the overall depth of the excavation, measured from a vertical line through the toe of the excavation face;

[]

"trench" means an excavation less than 3.7 m (12 ft) wide at the bottom, over 1.2 m (4 ft) deep, and of any length.

[276] Section 20.80 of the OHSR deals with nearby hazards and provides as follows:

Removing nearby hazards

20.80 Trees, utility poles, rocks and similar objects adjacent to an area to be excavated must be removed or secured if they could endanger workers.

[Emphasis added.]

[277] The need for and nature of shoring, benching or sloping in an excavation over four feet is dealt with in s. 20.81 of the OHSR as follows:

Sloping and shoring requirements

20.81 (1) Subject to section 20.78, before a worker enters any excavation over 1.2 m (4 ft.) in depth or, while in the excavation, approaches closer to the side or bank than a distance equal to the depth of the excavation, the employer must ensure that the sides of the excavation are

- (a) sloped as specified in writing by a qualified registered professional,
 - (b) sloped at angles, dependent on soil conditions, which will ensure stable faces, but in no case may the slope or combination of vertical cut and slope exceed that shown in Figure 20-1,
 - (c) benched as shown in Figure 20-2,
 - (d) supported as specified in writing by a professional engineer,
 - (e) supported in accordance with the minimum requirements of section 20.85, or
 - (f) supported by manufactured or prefabricated trench boxes or shoring cages, or other effective means.
- (2) If the end of a trench over 1.2 m (4 ft.) in depth is not adequately sloped, end shoring must be installed unless
- (a) a worker in the trench is not required to approach closer to the end of the trench than a distance equal to the depth of the trench at that end,
 - (b) where, for the prevailing soil conditions at the end of the trench, the permissible spacing of uprights equals or exceeds the width of the trench, or
 - (c) otherwise authorized in writing by a professional engineer or professional geoscientist.
- (3) If end shoring is required, the walers for the end shoring must be installed to bear against the walers that extend along the sides of the trench, or in a manner that will provide equivalent structural restraint.
- (4) End shoring must be designed by a professional engineer if the end shoring waler length exceeds 1.8 m (6 ft.).

- (5) Shoring must extend from at least 30 cm (1 ft.) above ground level to as close to the bottom of the trench as the material being installed will allow, but in no case more than 60 cm (2 ft.) from the bottom.
- (6) Shoring need not extend above ground level where traffic crossing plates need to be used, provided that other measures are taken to prevent excavated or other material from entering the excavation.

[Emphasis added.]

[278] From the foregoing in s. 20.81(1), safety precautions must be taken with respect to work in trenches of a depth of greater than four feet. These may include sloping or benching of the sides of the excavation, bringing in shoring cages, or otherwise supporting the sides of the excavation as specified by a professional engineer. The language in s. 20.81(1)(d) indicates that the sides of the excavation must be "supported as specified in writing by a professional engineer ". There is no option to simply forgo safety precautions if the contractor alone thinks the excavation is safe.

[279] Other aspects of the OHSR set out additional requirements for safe shoring procedures, trench support structures, spoil piles, sloping, and other requirements.

[280] Section 20.118 provides as follows:

Stabilizing walls

20.118 If a dangerous or unstable wall is to be left standing, it must be adequately braced.

[281] Excavated materials are dealt with in s. 20.90:

Excavated materials

20.90 (1) Excavated material must be kept back a minimum distance of 60cm (2 ft) from the edge of a trench excavation and 1.2 m (4 ft) from any other excavation.

(2) Under no circumstances may excavated material be piled so that it endangers workers.

[282] As noted above with respect to s. 20.81, in trenches greater than four feet deep, a company has three main options. It may use sloping or benching of the trench, bring in shoring equipment, or call in an engineer to provide an opinion. In Mr. Yip's experience with respect to practice in the industry, which I accept, if the engineer is likely to recommend sloping or shoring, a company would typically forgo the engineer's opinion and simply proceed to use shoring equipment or sloping of the sidewalls of a trench.

d) WorkSafeBC Guidelines

- [283] Part 20.78 and 20.81 were supported by WorkSafeBC guidelines (the "Guidelines"), which provide guidance on the application of the OHSR. The Guidelines state that verbal instructions from a qualified registered professional without supporting documents are insufficient, and if a certification is incomplete or considered inadequate, work should cease in the hazard area until acceptable certification is obtained or remedial work is completed to ensure the excavation complies with the regulations.
- [284] Dr. Hamidi stated, and I agree, that the Guidelines were not mandatory. They offered one way to comply with the OHSR scheme, possibly the best way, but the suggested method may not be the only way to comply. Thus, depending on the language and task involved, non-compliance with the Guidelines does not necessarily mean a failure to meet the proper standard of care.

IMPORTANT FACTUAL DISPUTES

1) Safety practices

- [285] The parties strongly disputed the issue of safety practices at J. Cote. While the Crown impugned J. Cote's safety practices, counsel for J. Cote argued that safety was a priority for the company and remained so on October 11, 2012. Counsel for Mr. Green argued that he ensured a safe workplace for his crew.

a) Safety Manual

- [286] Mr. Cote confirmed that a health and safety manual dated 1997 was the only safety document provided to workers on their first day at J. Cote up to and including 2012. He said that this manual was typically distributed informally at the jobsite and also stored in the foreperson's truck for general reference. The manual was not updated prior to the wall collapse. The company's safety manual was later updated on April 13, 2014, well after the fatal incident at the Edinburgh Laneway site.
- [287] Mr. Green indicated that in October 2012, he had a safety manual in his truck in case anyone wanted to review it.
- [288] Mr. Richer stated that he was not provided with a safety orientation or manual, nor did he receive any training on safety protocols or procedures when he started. He was not aware of any mechanism the company had in place to assess his knowledge of safety.
- [289] Mr. Huizenga is an independent witness whose evidence I accept. He testified that he was not provided with a safety manual or orientation upon commencing employment with the company and that all training was on-the-job.

- [290] Chad Allen testified that he was provided with a safety manual when he first started with the company. He testified that he received a half-hour orientation on his first day. He also testified that he had toolbox meetings. However, Mr. Allen was working under a different crew with a foreman (Mike Biemans), who I find was much more safety-minded than Mr. Green.
- [291] I find that the company's safety manual was not consistently reviewed with employees in any effective manner prior to their commencement of the Edinburgh Laneway Project.
- [292] Mr. Cote described what he considered to be a "formal orientation" system at J. Cote prior to October 2012. However, this primarily consisted of providing new employees with a copy of the company's safety manual, which they were expected to read. The reading of the manual and familiarity with safety procedures were not tracked in a formal way. Instead, the practice at J. Cote was for new workers to shadow a more experienced worker for one to two weeks. Mr. Cote described this approach as long-standing. He did not always meet new workers on their first day.
- [293] Mr. Cote claimed he reviewed the manual annually and was satisfied with its contents. A copy of the safety manual was filed in evidence. The content is partially outdated, uses generic language, and contains internal inconsistencies. The manual contained sections that were not part of the company's actual operations or were not followed in practice. Mr. Cote admitted the "Contaminant Monitoring Policy" on page 9.1 had nothing to do with their work. On page 4.1, the manual mandates that an orientation occur on the first day of the job and include at least a provision for written procedures and completion of a questionnaire. Mr. Cote conceded that no written procedures were provided, and no questionnaires were completed.
- [294] Further, the manual provided an "Inspection Policy" on page 6.1, which required regular inspections and report forms; however, in practice, inspections were conducted verbally, and forms were not regularly completed. For example, the "Construction Site Inspection Checklist" on pages 6.2-6.3 contained detailed and relevant items pertaining to excavations and first aid that were not documented through the provided templates on the Edinburgh Laneway Project.
- [295] The manual repeatedly references responsibilities of supervisors and foremen (ss. 1.4 and 1.5), including ensuring familiarity with WCB regulations, conducting toolbox meetings, and investigating unsafe acts.
- [296] Finally, although the manual included a "Periodic Review Policy" in s. 14.1, I find that the manual was not revised as of October 2012. I find that the company's practice of relying on the safety manual to establish safety protocols for trench work was ineffective. J. Cote lacked a formalized, effective safety program for excavation work and for identifying reasonably foreseeable hazards that could lead to the collapse of a retaining wall.

b) Safety Meetings

- [297] Mr. Green testified that toolbox meetings did occur. He referred to them as "chit chats" that occurred every morning at 7:00 a.m. He also referred to them as informal safety meetings. However, he could not be more specific in terms of any safety protocols that were reviewed. Mr. Green described the chit chats as involving his describing the work they were to be doing and how to perform it safely. He made no notes of such meetings occurring proximate to the accident. No records corroborate any formalized safety briefings by Mr. Green to his crew members on the Edinburgh Laneway site.
- [298] Mr. Richer stated that so-called "toolbox meetings" (weekly safety briefings) were irregular or non-existent on his crew, and that he never signed any documentation relating to safety orientations or procedures, which was never meaningfully contradicted by any credible documentary evidence. I accept this aspect of Mr. Richer's evidence.
- [299] This part of Mr. Richer's testimony is supported by the evidence of others. Mr. Huizenga was a labourer at the time of the incident. He worked for the company for two-and-a-half years prior to the incident. While he recalled that toolbox meetings sometimes occurred weekly and that brief morning discussions were held regarding the day's tasks, there was no indication that a structured or comprehensive safety training program was in place. Mr. Huizenga described receiving training only in the form of undocumented, task-specific, hands-on training, which was primarily given orally--for example, learning how to install water services, landscaping, or grounding manholes--and not in the identification or mitigation of workplace hazards.
- [300] Toolbox talks were referred to on pages 4.4 to 4.5 of the safety manual and were indicated in the manual to occur weekly, but they were rarely recorded by Mr. Green's team and only informally in those rare circumstances. Mr. Cote testified that he did not review records of toolbox talks.
- [301] Mr. Cote agreed that Mr. Bieman kept detailed notes of the toolbox meetings he conducted, which included employee signatures, a practice Mr. Cote confirmed had not been required in 2012 but was implemented only after the arrival of a safety consultant following the incident. Toolbox meetings with Mr. Green's team were general discussions and amounted to the tailgate meeting, the site-specific daily meeting. In that meeting, he expected the foreman to discuss the game plan for the day.
- [302] Mr. Cote was shown a series of toolbox talk records intended to illustrate how safety topics were communicated and documented at J. Cote prior to and after the October 2012 incident. While he confirmed that he occasionally reviewed these documents, he acknowledged it was not routine practice.
- [303] Mr. Cote agreed that Mr. Biemans' toolbox talks were more thorough but attributed this to variations in crew size and site complexity rather than differences in safety culture or supervisory diligence. He had never met with supervisors to improve the quality or consistency of toolbox talks, maintaining that they had always met his expectations. I find that the practice of toolbox talks, or so-called safety meetings, with crew members lacked

oversight and a focus on safety, and did not constitute a proactive, effective approach to safety management.

c) Hazard identification

[304] J. Cote did not have formalized hazard-identification practices other than on-the-job training, their own inspections, and reliance on an engineer's certificate.

[305] The Walden pre-construction video identified a crack or joint in the retaining wall on the east side. I have reviewed photographs of the crack or joint and find that it would have been readily visible to any inspector of the retaining wall prior to its collapse. I find that this, combined with the vertical construction joint between the two main sections of the retaining wall, should have caused a reasonable contractor to have concern about the stability of the retaining wall and the lack of reinforcement, and warranted further investigation. In addition, if the retaining wall had been examined prior to excavation, a construction crew might have discerned that the depth of the footing (being only 15 cm into the ground) and the lack of a horizontal footing were potential sources of risk.

[306] Mr. Cote, however, confirmed that there were no formal hazard assessment forms or standardized practices, and there was no structured training of any kind relating to hazard assessment. Mr. Cote entrusted his employees to conduct their own hazard assessments. Mr. Green testified that the procedure was for him, as foreman, to make his own hazard assessment. I find that there was no testing and no formal procedures in place for hazard identification.

[307] This was important for the risk posed by the retaining wall. Mr. Kidd stressed the importance of proactive risk assessment, which I find was not the practice at J. Cote.

d) Lack of Formal Training

[308] Although Mr. Green had considerable experience, I find that J. Cote never provided Mr. Green with any formal training in hazard assessment, trench safety, regulatory compliance, or the interpretation of geotechnical instructions.

[309] Mr. Green had taken a first aid course prior to the accident. He had completed other safety courses, including a course on workplace hazardous information materials and a confined spaces course. However, Mr. Green had not undergone any formal process to demonstrate these competencies prior to October 2012. Instead, training in hazard assessments and soil identification was informal and on-the-job, as was his training in selecting appropriate trench support structures. Mr. Green testified that his training in geotechnical reports consisted of going over them with Mr. Cote and Mr. Trigg.

[310] After the wall collapse, when J. Cote hired a safety officer, Mr. Green received training in soil identification and trench supervision. However, I find as a fact that prior to the accident, there was no formal testing, documentation, or written guidance given to Mr. Green about these subjects.

[311] Mr. Kidd testified that safety training from WorkSafeBC was available for hazard identification, in which construction workers completed inspection guides that were reviewed by supervisors.

[312] However, at J. Cote, there was no formal assessment process or documented verification of supervisor knowledge. Mr. Cote confirmed that there were no hazard assessment forms, no written action plans, and no classroom or structured training of any kind.

e) Conclusion with Respect to Safety Practices

[313] While Mr. Green and Mr. Cote testified that they prioritized a culture of safety, I reject their evidence on this issue. I find as a fact that there were no regular formal safety briefings, no formal hazard identification practices, or meaningful safety policies for Mr. Green's crew prior to the wall collapse. While seemingly minor on their own, these lapses were insidious because they represented a lack of safety redundancies that could have prevented the trench collapse.

[314] To its credit, J. Cote changed its practices after the 2012 wall collapse. The company shut down and revamped its policies and procedures to assure customers of its ability to perform work safely. It retained a safety consultant, implemented enhanced, more formal safety training, better documented its procedures, required workers to sign acknowledgment forms attesting that they had received training, and revised its safety manual.

[315] However, the evidence at trial revealed that prior to the wall collapse, J. Cote had an unstructured approach to hazard identification, safety practices and an absence of written procedures and training logs. I agree with the Crown that this system lacked the accountability and documentation required for proper safety oversight in a company operating in the high-risk field of excavation and trenching, which thereby increased the risks to workers.

2) Reliance on the October 2 Certificate

[316] A significant issue in this trial revolves around Mr. Yip's October 2 Certificate. Mr. Cote and Mr. Green relied substantially on the geotechnical certification prepared by Mr. Yip to justify the use of a two-foot setback at the Edinburgh Laneway excavation site. If their interpretation and reliance were reasonable, it would substantially undermine the Crown's case against them.

[317] Consistent with the approach in *Hundal and Creighton*, I would consider the objective standard of a reasonable supervisor or employer in the context of the circumstances known to the accused at the time.

- [318] The October 2 Certificate directed that "heavy loads/vibration of high intensity" be a minimum 0.6m setback from the trench edges. It deemed the trench "safe for entry by workers without use of any shoring systems and without having the trench sidewalls sloped or benched " The certification applied until October 16, 2022, provided there was no adverse change in conditions.
- [319] As noted above, there were two areas of potential ambiguity in Mr. Yip's certificate: 1) whether it spoke only to a static location, or to the entire trench excavation ahead; and 2) whether the term "loads" captured retaining walls and adjacent structures. How a reasonable supervisor would have interpreted the language in the certificate is critical.
- a) Application to Initial Position or Entire Trench
- [320] On the issue of whether the certification applied to the initial trench or to the excavation ahead, the accused argue that Condition 4 (certifying the trench as safe for worker entry) could be interpreted broadly. Condition 4 states in part: "Based on field inspection of the subsurface soil & groundwater conditions, the common trench with details shown on page 1 is deemed safe for entry by workers without use of any shoring ".
- [321] Mr. Yip insisted that his scope of work and the designation "safe for entry by workers" were limited to the initial trench location, not to the upcoming excavation along the laneway. Mr. Green and Mr. Cote interpreted this condition as applying to the entire trench for the period specified in the certificate.
- [322] Page 1 of the certification shows a large diagram of the trench at the initial position. It also includes a smaller, crude stick diagram of the laneway, showing the trench and manholes between Boundary Road and Gilmore Ave. As well, in terms of location, the top of page 1 refers to "AT THE LANE NORTH OF EDINBURGH ST, INTERSECTION WITH GILMORE AVE., HEADING WEST TO BOUNDARY RD, BURNABY, B.C."
- [323] There is therefore some basis for arguing in favour of a broad interpretation of the certification, beyond the trench's initial position. Even so, I have considerable difficulty with a wide interpretation of the certificate. Condition 4 states "based on the field inspection of the subsurface soil ... conditions," thus implying it was based on the location of Mr. Yip's inspection. Mr. Yip did not inspect the soil conditions in subsequent locations, and this fact would have been known to Mr. Green.
- [324] Was the misunderstanding by senior members of J. Cote reasonable? Objectively speaking, I cannot find that it was. A reasonable foreperson would have appreciated that:
- a) The certification was "[b]ased on field inspection of the subsurface soil & groundwater conditions," where Mr. Yip did an initial inspection.
- b) Soil conditions could change from one location to another.

- c) Geotechnical engineers have specialized knowledge and experience in soil mechanics, ground behaviour, and interactions with structures that senior officers of J. Cote did not have.
 - d) Mr. Yip only inspected the soil at the farthest east end of Edinburgh Laneway, and therefore could not have made an informed opinion of the underground conditions he never inspected.
 - e) Section 20.78 of the OHSR required that written instructions specify the support and sloping requirements, and the "subsurface conditions expected to be encountered." A geotechnical engineer could not predict the subsurface conditions expected to be encountered without having conducted an inspection of the immediate area.
 - f) As the trenchwork proceeded down the laneway, adjacent hazards would need to be specifically addressed, and there was no consideration of the size, shape, footings or mass of adjacent structures in the October 2 Certificate.
- [325] J. Cote operated in a fundamentally flawed manner. Their interpretation was premised on the assumption that they could dig based on a certificate from an inspector who neither reviewed the soil conditions nor assessed nearby hazards in the area to be excavated. Since sloping was not feasible because the south trench wall was vertical, the company should have used shoring on the south side of the trench wall based on the OHSR if it did not possess an engineer's certificate for the specific area where it was working. Essentially, the geotechnical certificate was like a building permit for trench work. Instead, J. Cote relied on the October 2 Certificate in a much broader way, believing it afforded them the flexibility to proceed along the trench route as long as they met requirements designed for the original trench site, dozens of yards away.
- [326] To be sure, there are ambiguities in the certification language, and the certificate could have been clearer. But s. 117(1) of the OHSR requires that every supervisor must "(b) be knowledgeable about this Part and those regulations applicable to the work being supervised." By virtue of s. 115(1), the employer was under an obligation to ensure that its employees were aware of their rights and duties under the OHSR. As Mr. Kidd indicated, "we're talking about people that are required to be familiar with how to do the work."
- [327] According to Mr. Green and Mr. Cote's interpretation, a geotechnical engineer could certify the safety of a deep trench that they had never inspected near hazards that were never assessed. It was a management-friendly interpretation which diverted hazard assessment to the prime contractor and eschewed the primary role of the engineer, who was best trained to assess changing soil conditions and do the risk-related calculations for nearby hazards. It undermined the philosophy of s. 20.81 of the OHSR, which embodies a redundancy by requiring the use of safety equipment or engineering approval to ensure the prime contractor's decisions adequately address worker safety. I find the interpretation of the October 2 Certificate by Mr. Green and Mr. Cote was unreasonable in the circumstances and inconsistent with industry norms, even if their views were honestly held and the

company was fortunate not to have had any accidents while operating under similar certificates from Mr. Yip in the past.

- [328] A reasonable person familiar with the regulations would know that the scheme requires greater care, particularly in high-risk situations involving deep trenches adjacent to other structures. Either shoring or sloping must be used, or an engineer must approve the specific area being worked on. The OHSR scheme demands no less.
- [329] If I am wrong in the above analysis and a more expansive interpretation was reasonably open to J. Cote, I find that, at the very least, a reasonable observer would perceive an ambiguity in the scope of the certification and seek clarification. A reasonable supervisor or company would appreciate that site conditions can vary from one location to another due to changes in soil conditions, nearby structures or improvements, groundwater conditions and weather, and that certification ought to be based on current conditions of a trench in a specific area. J. Cote's failure to clarify such ambiguity departed from the standard of care of a reasonable company in the circumstances.

b) Whether the Term "Loads" Captured Retaining Walls and Adjacent Structures

- [330] A second misunderstanding occurred around the language in condition 2 of the certification, which indicates as follows:

Limitations when machinery, load and/or vibration are in proximity: Keep heavy loads/vibrations of high intensity minimum 0.6 m setback away from the trench excavation cut edges lest soil failures may occur due to over-stress imposed in too close proximity. Do not sidecast spoil along the trench edges.

- [331] Mr. Yip testified that Condition 2 was intended to avoid soil failure by keeping vibrations away from the trench top edge. Mr. Yip, however, testified that the term "heavy loads" in Condition 2 was meant to apply only to temporary transient loads, such as the wheel of a truck. He did not mean it to include retaining walls.
- [332] Mr. Yip testified that he meant this condition to comply with s. 20.90 of the OHSR, which requires a minimum of 6000 millimetres (i.e., 0.6 meters or 24 inches) aside from the trench top. "Sidecast spoil" refers to soil material removed from the trench. He meant the reference to "heavy loads" to be a reference to transient loads, which can cause vibrations and destabilize the trench. Section 20.90 of the OHSR governs the placement of such transient loads and excavated material. Mr. Yip explained that, in his understanding, "heavy loads" is anything like the wheels of a dump truck, or heavy construction equipment, and that this condition applied to temporary, transient loads. To him, vibration of high intensity meant anything that vibrates, whether it may be a vibrating roller, a giant steel drum, or a roller compactor. He explained that the phrase "lest soil failure occur" refers to sliding soil. Soil could sheer off and fall into the trench wedge. He said that sloughing is the initial sign of soil failure.

- [333] Mr. Cote and Mr. Green, however, understood the reference to "heavy loads" as referring to any load. In other words, they interpreted Condition 2 as permitting them to trench near any improvement or structure, as long as they maintained a minimum distance of two feet.
- [334] Mr. Green thought that 'heavy loads' could mean every structure, including adjoining structures, wooden fences, machinery or trucks. Mr. Green testified that, "to me, a load is a load." He thought that he was being told to keep two feet away from anything and that as long as they kept two feet away, they were safe to dig.
- [335] Mr. Cote's evidence was similar. He said that the reference to "heavy loads" was typical of what he had seen in Mr. Yip's reports before. Mr. Cote believed a heavy load was something a person couldn't carry. If it needed a machine to carry it, then it was a heavy load. Although the language might have seemed awkward, he noted that English was not Mr. Yip's first language. During direct examination, Mr. Cote stated that "load" could include any nearby structure, but he also admitted he wasn't sure. He thought that a "load" was anything applying downward force on the trench.
- [336] Dr. Hamidi was adamant that the term "heavy load" could not be construed to refer to structures or improvements. He stated that he had never heard any engineer refer to any structure as a load. He stated that 'heavy loads' commonly refers to machinery in an excavation. Dr. Hamidi understood the term "load" to mean a movable object with weight.
- [337] Mr. Kidd testified that in his experience, 'heavy loads' referred to loads that were moving, not static things. Mr. Kidd interpreted Condition 2 as a direction to keep movable objects 0.6 meters away. To him, Condition 2 meant that one should not stock material or move machinery close to the edge of the trench. It did not pertain to structures. He did not interpret heavy loads as referring to structures or immovable objects. He stated, "That's not how I would read it at all." Mr. Kidd noted that the instruction does not specify the distance between the trench and improvements or structures. He thought the instructions needed to be clearer. I accept this evidence.
- [338] I note that the 2012 version of the OHSR did not use the term "load" to refer to structures. Within Part 20, which deals with Construction, Excavation and Demolition, and includes guidelines for trenching referred to above, the term load appears 49 times. Such references appear only in reference to movable things: for example, design loads (s. 20.6), loads from falling items (s. 20.9(3)), loads placed on a thrust-out crane landing platform (s. 20.13), temporary supports for loads placed upon structure or equipment during dismantling (s. 20.14), precautions for the application of loads to concrete structures (s. 20.23), and design requirements where loads are placed on lifting and bracing insert and anchor during panel lifting (s. 20.56). The term "load" is not used in relation to nearby hazards or structures.

- [339] I agree that there is some ambiguity in Condition 2 of the October 2 Certificate to keep "heavy loads" 0.6 m away from the trench edge. The term "heavy loads" was not defined in the certificate. I also accept some of J. Cote's arguments, such as the fact that they had seen similar certificates from Mr. Yip in the past, and they had no WorkSafeBC intervention in relation to such certificates.
- [340] Again, however, I cannot accept that J. Cote's interpretation is a reasonable interpretation to an informed construction supervisor, who is required to be familiar with the OHSR. I come to this conclusion for the following reasons:
- a) A general guideline in the industry, which is reflected in s. 20.78 of the OHSR, is to keep adjacent structures the same distance back as the depth of the trench, here at least eight feet. The departure from this rule of thumb, particularly with the vertical south wall of the trench, would have alerted a reasonable contractor to take extra care.
 - b) The OHSR requires spoil piles to be kept back 0.6 meters from the trench edge: s. 20.90. Applying the same 0.6 m setback to any adjacent structures would provide no additional protection for adjacent structures, which might have a more vertical mass and put more pressure on soil conditions close to the trench edge compared to a spoil pile.
 - c) J. Cote's interpretation that they could excavate within two feet of adjacent structures conflicted with the duty in s. 20.80 to remove nearby hazards "if they could endanger workers." This duty was a construction requirement that could not be waived by an engineer.
 - d) Mr. Yip conducted no specific assessment of adjacent structures on October 2, 2012, and the October 2 Certificate does not refer to the retaining wall or any other adjacent structures. No calculations of the added pressure on the trench wall as a result of nearby structures were indicated in the Certificate.
 - e) The October 2 Certificate did not clearly specify how far the trench should be from improvements or structures.
 - f) The term "load" was not used in the OHSR to refer to adjacent structures or improvements. J. Cote and its supervisors were required to be familiar with these regulations.
 - g) The ordinary grammatical meaning of the phrase "keep heavy loads away" appears to refer to a movable or transient load (something that can be kept away) rather than something fixed in one place.
- [341] J. Cote argued that Mr. Green and Mr. Cote honestly believed that the reference in the October 2 Certificate to "heavy loads" included the retaining wall and other structures. The company points out that the understanding of Mr. Green, Mr. Cote, and Mr. Allen was based on their years of working with Mr. Yip and receiving geotechnical reports from him. With respect, however, the central issue in the modified objective test is how a reasonable person in the same position would interpret the certificate. Based on the above, I am compelled to find that a reasonable person in the same circumstances would not have interpreted the

October 2 Certificate so broadly and would have foreseen a risk of bodily harm from deep trenching near hazards not assessed explicitly by an engineer.

- [342] Dr. Hamidi testified that a reasonable employer or supervisor would review the instructions with the engineer in advance and ensure that every part of the instructions was clear and manageable for the employer or supervisor. I accept his evidence on this point and find that this did not occur.
- [343] On the interpretation of the language "heavy loads" in Condition 2, I accept the interpretation of Dr. Hamidi and Mr. Kidd as representing the standard of care in the construction industry. I do not accept the broader interpretation offered by Mr. Green and Mr. Cote. While their understanding may have been honest, it was not an informed understanding consistent with the OHSR scheme or industry practice.
- [344] For these reasons, I find that J. Cote's interpretation of Condition 2 of the certificate was not reasonable.
- [345] As with Condition 4, at the very least, there was ambiguity in the scope of the engineer's certification that should have been flagged. I accept Dr. Hamidi's evidence that a reasonable foreman, faced with ambiguous language, should have immediately sought clarification and requested written supplemental instructions. Work should have ceased in the immediate area until an engineer's clear written instruction was provided.

ANALYSIS

1) Criminal Negligence Offences

- [346] I next consider the application of the elements of the criminal negligence-based offences to the facts in the case at bar.

a) Legal Duty

- [347] I find beyond a reasonable doubt that Mr. Green and J. Cote had a legal duty to ensure the safety of workers on the Edinburgh Laneway Project.
- [348] Section 217.1 of the Code states that everyone who undertakes or has the authority to direct how another person does work or performs a task has a duty to take reasonable steps to prevent bodily harm to such persons arising from that work or task. This provision applied to Mr. Green, Mr. Trigg, and Mr. Cote.
- [349] I find that Mr. Green was a senior officer as defined in s. 2 of the Code because he was a person responsible for managing an important aspect of the organization's activities. I find that Mr. Cote and Mr. Trigg were also senior officers within the same definition. All three were representatives of J. Cote. I find that the trench work on the Edinburgh Laneway Project was an important aspect of J. Cote's activities for which Mr. Green, Mr. Cote, and Mr. Trigg were responsible. J. Cote was therefore a party to their legal duties by virtue of s. 22.1 of the Code.

- [350] I find beyond a reasonable doubt that each of these senior officers breached their duty under s. 217.1 of the Code to prevent bodily harm to workers.
- [351] In addition, Mr. Green and J. Cote had duties under the WCA and the OHSR, as outlined above. As noted, J. Cote had the duty of an employer under s. 115 of the WCA to ensure the health and safety of workers. It also had the duties of a prime contractor under s. 118 of the WCA. I find beyond a reasonable doubt that J. Cote breached its duty to ensure the health and safety of its workers, specifically Mr. Caron and Mr. Richer.
- [352] Mr. Green had similar duties under s. 117 of the WCA as a supervisor to ensure the health and safety of all workers under his direct supervision and to be knowledgeable about this part of the WCA and the regulations applicable to the work being supervised. I find beyond a reasonable doubt that Mr. Green breached these duties.
- [353] The OHSR imposed duties on both Mr. Green and J. Cote with respect to the excavation work they conducted: ss. 20.78, 20.80, 20.81, 20.90 and 20.118 of the OHSR. Again, I find beyond a reasonable doubt the duties in s. 20.78(1)(b) (working in accordance with the instructions of a qualified registered professional when an improvement or structure is adjacent to the excavation), 20.80 (removal of nearby hazards), 20.81(1)(d) (sloping and shoring requirements), and 20.118 (stabilizing walls) were breached by Mr. Green and J. Cote.
- b) The Actus Reus
- [354] The actus reus of criminal negligence causing death requires that the accused undertook an act--or omitted to do anything that it was his or her legal duty to do--and that the act or omission caused someone's death: Javanmardi at para. 19.
- [355] As outlined above, Mr. Green and J. Cote failed in their legal duties to take reasonable steps to prevent bodily harm to workers and to use support equipment and stabilize the retaining wall. Their reliance on the October 2 Certificate will be considered as part of the mens rea analysis discussed below.
- [356] These failures by Mr. Green and J. Cote through its senior officers were a significant contributing cause of bodily harm to Mr. Richer and the death of Mr. Caron, without any intervening cause. These failures were both a factual and legal cause of the harm that resulted. In making this finding, I have considered the reliance Mr. Green and other senior managers at J. Cote placed on the October 2 Certificate. However, I would adopt the statement of Watt J.A. in *R. v. K.L.*, 2009 ONCA 141 that the criminal law does not recognize contributory negligence nor is it equipped with any mechanism to apportion responsibility for the harm occasioned by criminal conduct, except as part of the sentencing: see also, *R. v. Nette*, 2001 SCC 78 at para. 4. J. Cote and its senior officers retained ownership of the risks associated with the work they directed.

[357] I find beyond a reasonable doubt that Mr. Green and J. Cote breached their legal duties by omitting to take proper safety precautions during their work on the Project, and that as a result, their omission caused the death of Mr. Caron and bodily harm to Mr. Richer.

c) The Mens Rea - Marked and Substantial Departure

[358] The fault element is the most controversial element of the criminal negligence-based offences in this case. As noted above, the fault element is that the accused's act or omission "shows wanton or reckless disregard for the lives or safety of other persons": Javanmardi at para. 20.

[359] To prove that the accused showed a wanton or reckless disregard for the lives or safety of others, I would assess whether the Crown has proved the following beyond a reasonable doubt:

- 1) that the accused's conduct showed a marked and substantial departure from the conduct of a reasonable person in the circumstances; and
- 2) that a reasonable person in the same circumstances would have foreseen that this conduct posed a risk of bodily harm. "Bodily harm" is any hurt or injury that interferes with a person's health or comfort and is more than brief or minor.

[360] I will examine the requirements in reverse order.

i. Reasonable Foreseeability of Harm

[361] A reasonable supervisor is clearly expected to identify foreseeable hazards and take steps to address them. All the defence witnesses testified that those hazards were covered by the October 2 Certificate. I accept that reasonable reliance on the October 2 Certificate might weaken the inference that the risk of bodily harm was foreseeable in this context. However, as discussed earlier, I find that a broad interpretation of the authorizations in the October 2 Certificate was not reasonable in the circumstances.

[362] I have considered the defence arguments, including that none of the other engineers or experienced excavation workers who examined it expressed concerns about a risk, there were no observable changes in soil conditions along the Project from October 2-11, 2012, the wall appeared stable and properly built (though not reinforced), the expectation that the City of Burnaby would have constructed the wall correctly, and the difficulty in assessing the wall's stability partly because it was built on private property.

[363] Nevertheless, I conclude that a reasonable supervisor in the same circumstances would have foreseen the risk of bodily harm. I make this finding based on all the circumstances, including the following:

- a) The workers were working in the bottom of a trench that was at least two feet over their heads at standing height, and many feet over their heads at a crouching height.

- b) Trench work of this type was well-known in the construction industry as an inherently high-risk activity.
- c) The main section of the retaining wall spanned several more feet above the top edge of the trench.
- d) The retaining wall held back a substantial amount of earth on a downhill slope going toward the trench.
- e) The stability and reinforcement of the retaining wall were unknown.
- f) The retaining wall was sufficiently proximate to the trench that it and the mass of dirt behind it could fall into the trench if it collapsed.
- g) There was a visible joint in the middle of the retaining wall between the eastern and western sections.
- h) There was a visible joint on the east side of the retaining wall near a stairway.
- i) There was a visible joint with the sidewalk at the top of the retaining wall where it met the sidewalk.
- j) The sides of the trench were vertical or near vertical, meaning that there would likely only be escape to the sides of the trench in case of collapse.

[364] Here, the task of pipelaying in a deep trench was inherently dangerous and required specialized skill. As noted above, there were visual signs in the lack of reinforcement in the retaining wall, the obvious depth of the trench, and the proximity of the retaining wall that should have alerted Mr. Green and others to the risk of wall failure.

[365] I note that this conclusion aligns with that in *Fournier C.Q.*, where the president of an excavation firm was found guilty of manslaughter related to the collapse of an eight-foot trench onto a worker in the absence of shoring equipment. The Court in that case determined that the risk of bodily harm from the trench collapsing was obvious. The risk of bodily harm in the present case, with a six-foot retaining wall nearby, was equally or more apparent to a reasonable observer in the same circumstances.

[366] Here, I find that the risk of bodily harm was reasonably foreseeable because a knowledgeable industry supervisor would anticipate these hazards, even if not immediately visible. I also find that a reasonable and informed supervisor would not interpret the October 2 Certificate as addressing the danger posed by adjacent hazards, such as the retaining wall, because no such hazards were specifically mentioned in the certificate. A reasonable supervisor reading the certificate would have viewed it as having a more limited scope or sought clarification on any ambiguity.

ii. Marked and substantial departure

[367] I turn next to the central issue of whether the conduct of Mr. Green and J. Cote showed a marked and substantial departure from the conduct of a reasonable person or company in the circumstances.

[368] In evaluating this question, I would have regard to the totality of the circumstances, including the following:

- a) The language in the October 2 Certificate was less clear than it should have been, particularly in Conditions 2 and 4.
- b) Mr. Green, Mr. Cote, and Mr. Trigg adopted an unreasonable interpretation of the October 2 Certificate that was not consistent with the interpretation of a reasonable supervisor. A reasonable supervisor should have asked for clarification and stopped work until clear instructions were provided.
- c) The J. Cote crew exceeded the scope of the certificate by carrying on trench work in a deep trench without shoring or sloping between October 2 and 11, with a certificate that a reasonable supervisor would interpret as, at a minimum, lacking clarity as to whether it applied beyond the initial trench position.
- d) The senior officers of the company violated s. 20.80 of the OHSR by failing to remove or secure objects that could endanger workers. The wall posed an obvious risk due to its proximity to the trench. Mr. Yip never specifically certified that the wall did not pose a danger. The engineer could not waive this requirement.
- e) There were several signs of obvious danger in that the trench was at least eight feet deep, next to a wall that was closer to the trench edge than the depth of the trench. The wall extended above the trench by several feet.
- f) Workers were digging below what could be expected to be the footing of the wall.
- g) The workers were vulnerable in that they were often working in a crouched or bending over position, laying pipe on the floor of the trench.
- h) If the wall collapsed, it would likely collapse into the trench where the workers were working.

[369] I would also look at the wider context of the Edinburgh Laneway Project. In this regard, the added relevant considerations include the following:

- a) There were no meaningful safety or toolbox meetings with workers on Mr. Green's crew from October 2 to 11, 2025.
- b) There was no formal process for hazard assessment in relation to adjacent walls and structures along the trench way, and J. Cote did not continually assess new risks posed by adjacent hazards encountered along the laneway.

- c) Even if one were to assume, contrary to my finding above, that Mr. Yip did walk the laneway with Mr. Green, the retaining wall and the soil beneath the laneway had not been inspected in any meaningful way by Mr. Yip or any other engineer.
- d) The fragility of the wall should have been detected or assumed, based on the lack of available information about the wall's reinforcement, depth, and footing.
- e) The cracks or joints in the wall were a sign that the wall lacked lateral reinforcement to mitigate the risk of it falling over.

[370] With respect to Mr. Green, I take into account his prior training, experience, and qualifications as a foreman. His activity-specific knowledge and experience are relevant to determining whether the applicable standard of care was met: Javanmardi at para. 39. Nevertheless, every person, regardless of their professional training, is required to act in accordance with the standard expected of a reasonable person in the same circumstances: Javanmardi at para. 66.

[371] While I am highly critical of Mr. Green's omissions, I must place his actions on a continuum of negligence measured against the conduct of a reasonable supervisor in his circumstances. For some negligence-based offences, such as dangerous driving, a "marked" departure satisfies the fault element: *R. v. J.F.*, 2022 SCC 17 at para. 10. The offence of criminal negligence causing death is at the high end of a continuum of moral blameworthiness because the fault element requires a "marked and substantial departure": *Metron Construction* at para. 79; Javanmardi at paras. 19-21.

[372] Mr. Green made mistakes, as outlined above. But he also closed the trench every night with backfill, reviewed the project plans and the October 2 Certificate regularly, ensured the site was clean, and kept a close watch over his crew. Mr. Green was not lulled into a sense of security by the wall. He did not assume the wall was safe but instead mistakenly thought that the engineering certificate addressed the risk posed by the wall. Mr. Green himself walked up and down the laneway to measure where the trench would be located in relation to structures, including retaining walls. He adhered to the project plans with respect to the trench location. When the wall fell and the trench collapsed, he was quick to respond and attempt to have it lifted, though his efforts were too late to prevent harm to Mr. Caron.

[373] Mr. Green and Mr. Trigg had identified some possible issues in advance. This included a cinderblock wall that was badly damaged and ultimately had to be taken down. It also included a different large concrete wall that had anchors in it, which was assessed but ultimately not removed. Unfortunately, none of the senior J. Cote officers appreciated the danger posed by this six-foot-high retaining wall holding back a significant mass of soil, with visible gaps on each side of the wall and no visible sign of reinforcement.

[374] The language in the October 2 Certificate is critical here. As noted above, Mr. Green misinterpreted Conditions 2 and 4 of the certificate. While I find that a properly trained supervisor would have interpreted the certificate more narrowly or treated it as deficient

and sought clarification, I would make allowance for the fact that the language in Conditions 2 and 4 of the certificate has some ambiguity and that Mr. Green would not be expected to have the sophisticated level of familiarity in reading such certificates that more senior members of the company should have had.

- [375] Mr. Green's role was narrower than that of other senior officers, such as Mr. Trigg or Mr. Cote. He was the foreman of a four-person crew (including himself), responsible for executing the excavation plans, and operated under the direction of the superintendent and the company's president/owner. While I recognize his mandated obligations, he was in a junior-to-mid-level management role and did not have policymaking authority or the same degree of overall responsibility for health and safety as the superintendent and owner. For instance, Mr. Allen (the foreman on the second crew) testified that in 2012, Mr. Cote or Mr. Trigg usually made the decision on whether to call in a geotechnical engineer, and that the superintendent would typically decide which controls to use.
- [376] Mr. Green and Mr. Cote both testified that they had seen the word "loads" used by Mr. Yip in earlier reports and thought they knew what it meant. Nevertheless, trenching below the standing height of the workers was an inherently dangerous activity, and the reasonable person standard required heightened care, including careful attention to the limits of any geotechnical approval.
- [377] Mr. Green made a wrong conclusion based on poor judgment. As discussed in *R. v. Wood*, 2017 ONSC 3239, where an engineer certified the structural integrity of a mall building that collapsed, a conclusion based on poor judgment does not necessarily amount to a wanton or reckless disregard for the safety of others.
- [378] The marked and substantial standard represents a relatively more stringent standard of negligence. While Mr. Green's conduct falls short in several respects, I cannot characterize it beyond a reasonable doubt as a "marked and substantial" departure from the conduct of a reasonable supervisor.
- [379] I cannot find that Mr. Green's actions rose to the level of wanton or reckless disregard for the lives and safety of his workers. Assessing the whole of Mr. Green's conduct, I find that the Crown has not demonstrated beyond a reasonable doubt that it amounts to a marked and substantial departure from the care of a reasonable supervisor in his position in the circumstances.
- [380] I view J. Cote's liability differently because the company's overall approach to safety, as evidenced by the collective actions of its senior officers, paints a more complete picture of a significant departure from the requisite standard of care. As noted above, the liability of a corporation under s. 22.1 of the Code may be made up of the collective actions or omissions of one or more of its senior officers where one of its representatives is a party to the offence. Pursuant to that section, the corporation must be taken to have wider knowledge and responsibility, including collective responsibility, by its senior officers. The company cannot avoid accountability by fragmenting responsibility among senior officers.

- [381] Worker safety was not a shared responsibility. Section 4.2.1 of the MMCD meant that J. Cote alone was responsible for all aspects of safety on the Edinburgh Laneway Project.
- [382] Collectively, Mr. Cote, Mr. Green, and Mr. Trigg misinterpreted the geotechnical certificate and omitted to detect and respond to the hazard presented by the retaining wall. This was not a momentary lapse of attention. The company operated under this misapprehension for more than a week, between October 2 and 11, 2012. There was sufficient time in this interval for senior or more informed officers, other than Mr. Green, to monitor ongoing project risks and, if necessary, review and clarify the authorized scope of the trenchwork in the October 2 Certificate.
- [383] In addition, the company bears collective responsibility for its failure to implement more effective safety practices, such as safety meetings, a more formal hazard identification protocol, and better staff training, which could have identified the risk of the wall's collapse if the company had adopted a more proactive approach to safety.
- [384] While each of the actions and omissions of the senior officers in isolation might not rise to the level of a marked and substantial departure from the reasonably prudent supervisor or owner, I find there was an organizational failure here to ensure adequate safe practices. The senior officers should have detected and addressed problems with the October 2 Certificate and the lack of safety procedures to identify hazards. As well, greater care should have been taken at the senior management level to ensure that Mr. Green received appropriate training, hazard assessments were conducted, adjacent structures were addressed, communications with the geotechnical engineer ensured instructions were understood, and employees were cautioned on safe practices.
- [385] In assessing the degree of fault J. Cote is liable for, I recognize that J. Cote was a professional construction company experienced in public construction work. I accept that they had performed considerable excavation work prior to this incident without difficulty, including working with Mr. Yip. Such an experienced company operating in a highly regulated context does not carry the obvious antecedents of criminal behaviour. Evidence from WorkSafeBC indicates that their enforcement measures are often aimed at learning what went wrong and educating industry actors to prevent recurrence.
- [386] However, the circumstances surrounding the October 11, 2012, incident were more concerning because of the failure to take precautions in high-risk excavation work. As well, corporate liability must be understood in light of s. 22.1 of the Code, which can make companies liable for the collective failure of their senior officers. I find that much greater care and attention to the prevention of foreseeable hazards was called for when J. Cote engaged in high-risk activity that posed an obvious and significant threat to worker safety: Javanmardi at para. 37; Fournier C.Q. at paras. 119, 120, 129, 132. In short, the appropriate standard of care here must recognize the need for increased vigilance and caution because of the high-risk nature of trenching at least eight feet down near obvious, adjacent hazards of unknown stability--a risk that J. Cote itself created.

- [387] J. Cote argues that they believed that excavating the section of the laneway that ultimately collapsed was safe. They submit that their senior employees relied on their many years of experience, including their past work with Mr. Yip. The problem with this submission is that it tends to introduce subjective factors into what is fundamentally an objective analysis, modified to the activity and the circumstances.
- [388] J. Cote's argument is analogous to a driver misinterpreting a Canadian highway speed sign as being 100 miles per hour, when it actually refers to kilometres per hour. It is not an adequate response to a high-speed collision that the driver had long interpreted the signage in this manner and had sped swiftly along without incident or being pulled over by the police. "We've always done it this way" does not, by itself, establish that reasonable steps are in place to prevent bodily harm in high-risk workplaces, even if such procedures have not yet resulted in harm to workers. In other words, individual excusing conditions, such as the experiential characteristics of the accused, inject unwarranted subjectivity into the analysis, which undermines the purpose of having a single and uniform legal standard: *R. v. Goforth*, 2022 SCC 25 at para. 41.
- [389] In the circumstances here, there is no doubt that J. Cote should have used shoring or bracing equipment in their trenchwork or further consulted an engineer as they approached the adjacent hazard of the retaining wall. While I take into account the training and experience of the senior officers, the company's past practices and experiences provide little assistance in assessing the extent to which the company departed from the standard of care of a reasonable person in the same circumstances. A reasonable company would have used shoring equipment to protect its workers and would have had safety procedures in place to ensure that potential hazards, such as the retaining wall, were identified.
- [390] I find beyond a reasonable doubt, based on the party provisions in s. 22.1(a) of the Code, that J. Cote was a party to the offence by virtue of the collective actions and omissions of its representatives, being primarily Mr. Green but also Mr. Trigg and Mr. Cote. Under s. 22.1(b), J. Cote bears responsibility for the collective failure of its senior officers to foresee and prevent the collapse of the retaining wall.
- [391] That failure amounted to a collectively inadequate response to trench safety attributable to J. Cote. The company's failures (which comprise the aggregate omissions of its senior officers) include its failures to adopt a more proactive approach to safety, to appreciate the instability or unknown stability of the retaining wall, to better educate its workers including provision of an up-to-date safety manual, to implement effective safety meetings, to adopt proactive hazard identification practices, and to detect and correct the ambiguity in the scope of the October 2 Certificate. In terms of degree, I find this conduct collectively represents a marked and substantial departure from the expected norm and is properly characterized as a reckless disregard for the lives and safety of the workers in the trench in these circumstances.

[392] I find that the Crown has proven beyond a reasonable doubt that the senior officers of the corporation, for which J. Cote is liable under s. 22.1 of the Code, collectively, substantially, and markedly departed from the required standard of care in the circumstances in a manner sufficient to establish a conviction for criminal negligence causing bodily harm and death.

2) Unlawful Act Manslaughter

[393] Mr. Green is additionally charged with unlawful act manslaughter.

[394] As noted in Javanmardi at para. 17, there is a great deal of overlap between unlawful act manslaughter and criminal negligence causing death. Nevertheless, the offences must be approached differently.

[395] The actus reus of unlawful act manslaughter requires the Crown to prove that the accused committed an unlawful act and that the unlawful act caused the death. The predicate offence in Mr. Green's case includes the violation of s. 217.1 of the Code (the legal duty imposed on those who direct work to take reasonable steps to prevent bodily harm), s. 117(1)(a) of the WCA (ensuring the health and safety of workers under direct supervision), and s. 20.78(1)(b) of the OHSR (duty to conduct excavation work in accordance with the written instructions of a qualified registered professional if an improvement or structure is adjacent to the excavation). As in Fournier C.Q., I find that the failure to shore the walls of a trench in violation of health and safety regulations is an unlawful act for the purposes of s. 225(a) of the Code.

[396] The fault element is more difficult. Where the predicate offence is a strict liability offence, the fault element requires a marked departure from the standard of care expected of a reasonable person in the circumstances: Javanmardi at para. 31.

[397] In making this assessment, I would have regard to the October 2 Certificate that Mr. Green and others misinterpreted. As noted above, I acknowledge that there was some ambiguity in the engineering certificate that might fool a casual or untrained reader. Mr. Kidd testified, and I accept that the report was deficient and not fit for purpose, in that it did not address adjacent structures and did not contain adequate instructions on how to dig going forward. In Fournier C.Q., the same issue of misinterpreting an engineering certificate did not arise.

[398] As counsel for Mr. Green notes, the Crown's case against him, at least as initially framed, relied heavily on evidence from Mr. Richer regarding unsafe practices and warnings that I have found I cannot accept. Much of the rest of the Crown's case against him depends on his interpretation of the October 2 Certificate, which I found to be unreasonable. In addition, Mr. Green can be criticized for failing to conduct a specific hazard assessment of the retaining wall and for failing to implement safer procedures, such as meaningful safety meetings with his crew.

- [399] I note that as a supervisor, Mr. Green had a duty to ensure the health and safety of workers under his supervision (s. 117(1)(a) of the OHSR) and to be knowledgeable about the OHSR (s. 117(1)(b)). However, as Dr. Hamidi noted, foremen typically focus on day-to-day operations and address site-specific tasks, rather than assuming the overall responsibility for planning, oversight, and safe practices that the superintendent, owner, and, ultimately, the prime contractor must assume.
- [400] I am obliged to consider Mr. Green's training, experience, and qualifications as a foreman: Javanmardi at paras. 37-39. As noted above, while Mr. Green had considerable on-the-job experience, as a junior to mid-level foreman he lacked the higher level of training and knowledge in assessing geotechnical certificates that would be expected of a more senior officer. As noted, Conditions 2 and 4 of the October 2 Certificate carried some not insignificant ambiguity, and the blatancy of the problems in the language of the October 2 Certificate must be understood in light of his training by Mr. Cote, who had traditionally interpreted Mr. Yip's certificates more broadly. Again, I accept Mr. Allen's evidence that it was traditionally Mr. Cote or Mr. Trigg who called in the geotechnical engineer and decided which controls to use.
- [401] Mr. Green's role was field-specific and more limited than that of the superintendent or owner in that he did not have the ability or responsibility to determine the company's overall approach to safety. The trench collapse was due in part to Mr. Green's omissions and improper decision-making, but it was also a byproduct of the company's overall approach to safety, much of which was not within Mr. Green's domain.
- [402] In the circumstances, while Mr. Green's actions or inactions may rightfully be faulted, in assessing the degree of fault, I am not satisfied the Crown has proven beyond a reasonable doubt that Mr. Green's conduct amounted to a marked departure from the norm for a person operating in his role with his level of training and experience.
- [403] I would acquit Mr. Green of the offence of unlawful act manslaughter.

CONCLUSION

- [404] Mr. Green, stand up please. I find you not guilty on all charges. You may be seated.
- [405] I find the Crown has proven the guilt of J. Cote and Son Excavating Ltd. on counts 1 and 2 beyond a reasonable doubt. Convictions will be entered against the company on those counts.
- [406] I express my appreciation to all counsel for their capable handling of this challenging case.
- "Brundrett J."

Appendix A

The October 2, 2012 Earthbitat Certificate (Exhibit 72)

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Prepared on 27 October 2026 · Esheria