



**Ontario
Ministry of
Labour**

Occupational Health & Safety Branch
Provincial Coordinator's Office – Mining
933 Ramsey Lake Road
Sudbury ON Canada P3E 6B5

**REPORT
OF
THE MINING HEALTH AND SAFETY
PROGRAM
FOR
*2004 and 2005***

This Report is prepared for the purpose of publicizing the types of incidents that are occurring within the mining industry and their causes.

It would serve this purpose best if the Report, or appropriate components, were made available to front line supervisors, workers, and health and safety committees.

This Report contains all of the Initial Report on fatalities since the last Report of 2003.

TABLE OF CONTENTS

FATALITIES FOR 2004 ➤ Chris White

FATALITIES FOR 2005 ➤ Igor Lobko

JURY RECOMMENDATIONS

- Serge Blais
- Jerome Burns
- Shawn Cooper
- Phil Fischer
- Rodney Harten
- Andy Lamoureux
- Brian Smith

NOTICES

Changes to Regulation 854/90 for Mines and Mining
Plants: "Confined Space"

REPORTABLE INCIDENTS

- INDEX
- Incidents received from Jan. to Dec. 2004
- INDEX
- Incidents received from Jan. to Dec. 2005

2004 FATALITY – INITIAL REPORT

Name: Chris White
Employer: Musselwhite Mine
Location: Thunder Bay, Ontario
Incident: On June 28, 2004, Chris White was conducting gas monitoring tests with his co-worker. There was a recent blast so they were checking the bottom and then proceeded to test at the top of the stope. For some unknown reason, Mr. White stepped under the barricade chain, walked over to the hole and disappeared in the open stope.

2005 FATALITY – INITIAL REPORT

Name: Igor Lobko
Employer: Kirkland Lake Gold Inc.
Location: Kirkland Lake, Ontario
Incident: On December 14, 2005, Igo Lobko, age 50, was hoisting up drill through manway when he slipped and fell approximately 200 feet where he received fatal injuries.

Ministry
of
Labour

Ministère
du
Travail



Office of the Assistant Deputy Minister
Operations Division
400 University Avenue
14th Floor
Toronto, ON M7A 1T7
Telephone: (416) 326-7667
Facsimile : (416) 326-7599

Bureau du sous-ministre adjoint
Division des opérations
400, avenue University
14^e étage
Toronto ON M7A 1T7
Téléphone: (416) 326-7667
Télécopieur: (416) 326-7599

April 29, 2005

Barry A. McLellan, M.D., FRCPC
Acting Chief Coroner for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. McLellan:

Re: Inquest into the death of Serge Blais Deceased April 14, 2003 Your File Number: 2004-41

With reference to the recommendations of the Coroner's Jury regarding the above-mentioned fatal incident, I have received the enclosed report from the Provincial Coordinator of the Mining Health and Safety Program, Operations Division. This report was prepared in co-operation with appropriate staff in the Ministry of Labour.

I have forwarded copies of this report and the recommendations of the Jury to the organizations listed below:

Deputy Minister, Ministry of Transportation
Librarian, Mines and Aggregates Safety and Health Association
General Manager, Mines and Aggregates Safety and Health
Technical Specialist, Information Projects, Canadian Centre for
Occupational Health and Safety
Assistant Professor, School of Environmental Health, Ryerson Polytechnic University
Lawyer, Toronto Workers' Health and Safety Legal Clinic
Vice President, Prevention, Workplace Safety and Insurance Board
Co-ordinator, Volunteer Activities, Industrial Accident Prevention Association
General Manager & CEO, Municipal Health and Safety Association
Deputy Minister, Ministry Of Labour

Please let me know if you wish to discuss any aspect of this matter with me or my officials.

Yours truly,

Helle Tosine
Assistant Deputy Minister

Enclosure

**SUMMARY OF CIRCUMSTANCES
CONTRIBUTING TO THE DEATH OF**

Serge Blais

**Deceased April 14, 2003
Johnson Brothers (Bothwell) Limited**

Date of Inquest : October 7 & 8, 2004

Quoted from coroner's report

"The deceased, a truck driver with more than a decade of experience was crushed in the cab of his tractor when the trailer toppled over onto it. The trailer was a hydraulically operated dumping (through the rear) type used for hauling and dumping sand and/or gravel. The trailer was in the process of dumping at a gravel pit, owned and operated by his employer, when the accident occurred. It was daylight with a moderate wind. There were no eyewitnesses to the incident. Another driver happened on the scene (likely within several minutes) and initiated a response through 911.

Extrication was difficult and took almost 1 hour from the scene. The driver was declared dead on arrival at the receiving hospital where he was taken by air ambulance. The driver was found to be sober and in reasonable health. He died as a direct result of the injuries sustained.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Serge Blais

**Deceased April 14, 2003
Johnson Brothers (Bothwell) Limited**

Date of Inquest : October 7 & 8, 2004

As requested, the following is the Ministry of Labour's (MOL's) response to recommendations #1 to #9.

The responses to recommendations 1, 3, 4, 6 and 2, 5 and 7 to 9 are grouped together, due to their similarities.

Re: Recommendation No. 1

"It is recommended that surface mining companies put training requirements and specific safety procedures in written form. These should be made available to all employees both new and existing.

Rationale: At this inquiry, evidence suggested that the main means of communication regarding safety practices was done verbally".

Re: Recommendation No. 3

"We recommend that the Ministry of Labour encourage employers in the trucking industry to have training manuals or training plans for employees to operate company vehicles.

Rationale: In this case, there was no documented evidence of proper training of drivers".

Re: Recommendation No. 4

"That Surface Mining Operators be encouraged to establish a manual for training new drivers and ongoing training of employees, making sure all employees are aware of new safety measures.

Rationale: In this case, there is no documented evidence of ongoing training of employees"

Re: Recommendation No. 6

“That the Ministry of Labour in cooperation with the Ministry of Transportation develop additional training for individuals with AZ licenses.

Rationale: In this case, there was no evidence of additional training of employees on how to operate specialized vehicles. Testimony was given that there are “Tip Over Prevention” Programs available”

MOL inspectors routinely review training of workers and write orders when the training materials and training records are not in written form. Written training materials help ensure training consistency and written training records are a good indication that training has been given. Recommendation #1 will be discussed with the Mining Legislative Review Committee (MLRC) to determine if the regulations should be amended to require written training materials and records. The MLRC is a tripartite committee that advises the Minister on matters of health and safety in the mining industry.

Work procedures should also be in written form to ensure completeness and consistency. MOL inspectors have and will continue to write orders to ensure procedures are in written form.

Since this fatal incident, the employer now records all training and has put training materials and operating procedures in written form.

The MOL is discussing with the MTO the content of the training for an A-Z licence but it is not likely that the detail suggested in the recommendation will be in the training. The site specific detail including dumping is best taught at the specific work site given the variety of trucks and diversity of the worksites.

Re: Recommendation No. 2

“It is recommended that surface mining companies establish a written Emergency Response Plan that includes notification of relatives of employees involved in serious accidents.

Rationale: In this case, there was no Emergency Response Plan in written form”.

Re: Recommendation No. 5

“That the Ministry of Labour either establish or encourage employees in the trucking industry to consider drafting plans for potential emergency action plans

Rationale: In this case, there was one person in charge of safety and no plans of action or hierarchy of command”

The MOL is presently drafting a guideline for the industry to assist employers to develop emergency preparedness plans. This guideline will be distributed to the mining industry and MOL inspectors will ask to see these plans while conducting inspections.

Contacting family members is an important part of the plan and should be done in a timely fashion to enable the family to attend an injured worker.

Re: Recommendation No. 7

“That Surface Mining Operators are to have a supervisor where possible to check on the dumping of loads.

Rationale: In this case, there did not seem to be consistent or reliable supervision or communication at individual sites”

Re: Recommendation No. 8

“We recommend that the Ministry of Labour consider developing more specific guidelines regarding acceptable distances for the manoeuvring of vehicles so that dumping as close to 0 degrees is possible.

Rationale: In this case, the manoeuvring distance available to the driver was questionable”

Re: Recommendation No. 9

“We recommend that Surface Mining Operators review current dumping practices and take steps to ensure that all hazards are clearly posted.

Rationale: There was no evidence of visual indicators on site pertaining to hazards. For example: signs/illustrations”

The Regulations for Mines and Mining Plants under OHSA require that dump points be planned properly and dump points adequately designed. It is important that workers be properly trained in dumping practices specific to the workplace and procedures developed, followed, and work practices and conditions monitored to ensure workers are not at risk while dumping. Each workplace is different and this requires specific procedures and training. The supervisor is required to advise the worker of any potential and actual danger to the worker that the supervisor is aware of. This applies to all workplace activities and not just dumping. The surface mine operators must appoint a competent person when appointing a supervisor as is the case with all employers.

The Occupational Health and Safety Act (OHSA) requires employers to provide training appropriate to the type of work: The provision of training specific to the work site and to the truck being driven is the responsibility of the employer. Due to the variety of vehicles used and the diversity of worksites, development of a regulation to address every eventuality would be impractical.

The MOL agrees that all hazards should be posted. The worker must be made aware of hazards by any means that effectively warns a worker of a hazard. This is a requirement of employers and supervisors in the OHSA.

Ministry
of
Labour

Ministère
du
Travail



Office of the Assistant Deputy Minister
Bureau du sous-ministre adjoint
Operations Division
400 University Avenue
14th Floor
Toronto, ON M7A 1T7
Telephone: (416) 326-7667
Facsimile : (416) 326-7599

Division des opérations
400, avenue University
14^e étage
Toronto ON M7A 1T7
Téléphone: (416) 326-7667
Télécopieur: (416) 326-7599

June 21, 2004

Barry A. McLellan, M.D., FRCPC
Acting Chief Coroner for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. McLellan:

Re: Inquest into the death of Jerome Burns - Deceased November 22, 2000 Your File Number: Q2003-44

With reference to the recommendations of the Coroner's Jury regarding the above-mentioned fatal incident, I have received the enclosed report from the Provincial Coordinator of the Mining Health and Safety Program, Operations Division. This report was prepared in co-operation with appropriate staff in the Ministry of Labour.

I have forwarded copies of this report and the recommendations of the Jury to the organizations listed below:

Executive Vice-President & General Manager, Construction Safety Association of Ontario
Coordinator, Patient Relations, Peterborough Regional Health Centre
President, Canadian Farm and Industrial Equipment Institute
Technical Specialist, Information Projects, Canadian Centre for Occupational Health and Safety
General Manager, Ontario Forestry Safe Workplace Association
President and Chief Executive Officer, Industrial Accident Prevention Association
Assistant Professor, School of Environmental Health, Ryerson Polytechnic University
Lawyer, Toronto Workers' Health and Safety Legal Clinic
Vice President, Prevention, Workplace Safety and Insurance Board
Co-ordinator, Volunteer Activities, Industrial Accident Prevention Association
General Manager & CEO, Municipal Health and Safety Association
General Manager Mines and Aggregates Safety and Health Association
President and Chief Executive Officer, Placer Dome Canada limited
President, Ontario Mining Association
Executive Director, Canadian Trucking Association
Deputy Minister, Ministry of Labour

Please let me know if you wish to discuss any aspect of this matter with me or my officials.

Yours truly,

Helle Tosine
Assistant Deputy Minister

**SYNOPSIS OF SIGNIFICANT FACTORS
CONTRIBUTING TO THE DEATH OF**

Jerome Burns

**Deceased November 22, 2000
Placer Dome Musselwhite Mine**

Inquest Date: June 24-27, 2003

On November 22, 2000 at approximately 5:00 p.m., Mr. Jerome Burns and his partner were removing a tire on a 30-ton underground haulage truck when the tire exploded outward striking and fatally injuring Mr. Burns and critically injuring his partner. They were employed by Musselwhite Mine and were working in the surface garage of Placer Dome (CLA) Limited. Mr. Burns was later pronounced dead at the nursing station.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Jerome Burns

**Deceased November 22, 2000
Placer Dome Musselwhite Mine**

Inquest Date: June 24-27, 2003

The Ministry of Labour (MOL) has responded to all the recommendations whether or not they were specifically directed at the MOL. The MOL response is meant to guide the chief coroner and provide context for the recommendations.

Recommendations 1&2, 3&4 and 6&7 respectively, are being addressed together due to their similarity.

Re: Recommendation No. 1

“The Ministry of Labour should provide an appropriate guideline or regulation to require that, for multi-piece wheel rim assemblies on heavy equipment (in all operations and shops where it is used or serviced) the tires be deflated fully as the first step in removing a wheel assembly from a vehicle. However, the Ministry of Labour shall immediately sent out an Alert to all members of the industry using multi-piece wheel rim assemblies on heavy equipment to immediately start deflating all tires when removing the wheel assembly, pending preparation of these Ministry guidelines and regulation.”

Re: Recommendation No. 2

“The Ministry of Labour should provide an appropriate guideline or regulation for any operation or shop using or servicing large industrial wheel rim assemblies to develop and implement a written procedure for the systematic and thorough inspection of rims, such as, using dye penetrant testing, magnetic particle testing, ultraviolet light or other suitable testing means. These inspections should be documented and the documents should be made available to those servicing the rims. The Ministry of Labour shall follow-up within the industry to ensure that these practices are being followed.”

The MOL agrees with recommendations number 1 and number 2. Accordingly, beginning in 2000, the MOL in partnership with the Mines and Aggregates Safety and Health Association, the Ontario Mining Association, the Ontario Mine Contractors Safety Association, and the Aggregate Producers Association of Ontario took the following action to address the hazards of exploding tires and rims:

- A review of the section in the “*Regulations for Mines and Mining Plants*” (Regulations) regarding rubber tires and multi piece rims. -The review was done by the MOL and the Mining Legislative Review Committee (MLRC). The MLRC is a bipartite committee whose mandate is to advise the Minister of Labour on matters of health and safety for the mining industry. The result of this review suggested that the Mining Regulation be amended to include requirements for protective devices for the protection of workers when working on energized rubber tires with multi piece rims. This amendment was filed as O.Reg. 31/04 on February 27, 2004 and was gazetted in March 2004.
- A Health and Safety Guideline titled “Working with Tires and Wheel Assemblies” was developed by the MOL, MASHA and representatives of the tire industry and distributed to the mining industry. The guideline addresses worker training, procedures and protective devices to be used when work is performed on rubber tires and wheel assemblies.
- The MOL and the Mines and Aggregates Safety and Health Association (MASHA) developed an Alert titled “Split Rim Wheel Assemblies” and an Information Bulletin titled “ Damaged Wheels and Rims” The Alert recommends:
 - auditing all wheel and tire assemblies and identifying the rims in use;
 - reviewing the manufacturers’ procedures for maintaining all makes and types of wheels and tires in use;
 - establishing a policy of deflating all tires by removing the valve core prior to loosening any fasteners or beginning disassembly;
 - following appropriate safe procedures for inflating all types of tires and use of a wheel cage or stand-off inflation device.

The Information Bulletin contains information regarding damage to rim components and recommends that all rims be visibly examined, periodically sand blasted and non-destructively tested for cracks. It also specifies that the non-destructive testing be done by qualified persons.

In November 2003 the MOL sent a letter to the mining industry reminding them of the importance of non-destructive testing.

- MASHA and the MOL developed a video regarding the hazards of tires and rims. This video was made available to the mining industry.
- MOL Inspectors conducted targeted inspections of mine sites where work on tires was being done. While conducting inspections, Inspectors requested to see what procedures were in place for the protection of workers working on tires and proof that workers had been trained for the work they were performing. MOL Inspectors continue to inspect for proper training, procedures and protective devices where mine workers are working on tires and rims.
- Inspections revealed that some mines employ experienced tire suppliers to do all work on tires. The MOL is of the opinion that the risk of injury to workers can be reduced if this work is done by an experienced tire supplier or by properly trained mine employees.

The “*Occupational Health and Safety Act*” (OHSA) requires the employer to provide information, training and supervision for the protection of the worker. In addition the employer is required to maintain equipment in good condition.

Re: Recommendation No. 3

“The Ministry of Labour should require courses for qualifying heavy equipment mechanics during the apprenticeship program to include training which emphasizes the dangers associated with tires and rims, and safe practices for working around such equipment. There should be periodic refresher courses subsequent to such training.”

Re: Recommendation No. 4

“The Ministry of Labour should require all owner/operators of heavy equipment who undertake to change or repair tires, to be required to obtain training emphasizing the dangers associated with tires and rims, and safe practices for working around such equipment. There should be periodic refresher courses subsequent to such training also required by the Ministry of Labour.”

The MOL agrees that proper and adequate training that includes hazard identification is critical for work involving heavy equipment and would point out that the requirement for proper training currently exists in OHSA. OHSA also requires the employer to ensure that measures and procedures as prescribed, are in place. The procedures are referred to in the regulations.

Re: Recommendation No. 5

“The Ministry of Labour and all industries using multi-piece wheel rim assemblies should comply with the Australian Standards, Section 4, Examination of Rims and Wheels (Exhibit #6 attached) and this should be considered for possible adoption into the Ministry Guidelines.”

Under the OHSA an employer must take every precaution reasonable in the circumstances for the protection of a worker. This may include following the standards and guidance material relating to work on tires and rims. In addition to the standard mentioned in this recommendation, the MOL, in its Health and Safety Guideline “Working With Tires and Wheel Assemblies” makes reference to several other standards that are relevant to tire and rim work. These are:

- a) OSHA - Servicing multi-piece and single piece rim wheels – Regulation.
- b) Mines and Aggregates Safety and Health Association - Technical Report entitled "Tire Explosions Due to Pyrolysis".
- c) Mines Department of Western Australia - Summary of Proceedings of the Seminar on Tyre Fires and Explosions - Causes and Prevention - Kalgoorlie, Western Australia - May 4-5, 1988.
- d) Mine Safety and Health Administration - Tire and Rim Safety Awareness Program - dated 1996.
- e) Ontario Ministry of Skills Development - Apprenticeship Training Standards - Tire, Wheel and Rim Mechanic.
- f) The ACCURIDE Corporation - Rim/Wheel Safety & Service Manual.
- g) Hazard Alerts produced by the Ontario Ministry of Labour entitled “Explosion of Tires Ring During Repair” and “Worn or Aging Tire Rims and Components”.
- h) Hazard Alert by Saskatchewan Labour – “Tire Mount/Demount on Heavy Vehicles” – based on a fatality on February 14, 1998.

- i) Ontario Regulations under the Apprenticeship and Certification Act and training and certification by the Ontario Trucking Association.
- j) National Wheel and Rim Association - "Wheel and Rim Safety Manual"

Re: Recommendation No. 6

"The Ministry of Labour and all industries using multi-piece wheel rim assemblies should require further research to be conducted by engineers to construct a tire cage or a holding device to contain these large multi-split rims and tires during inflation."

Re: Recommendation No. 7

The Ministry of Labour and all industries using multi-piece wheel rim assemblies should require further research to be conducted by engineers to manufacture a better quality, (e.g. thicker and stronger) safer rim for heavy equipment."

MOL agrees with the general intent of recommendations 6 & 7 and would encourage the use of tire cages or other holding devices used when work is done on tires and rims. This is addressed in the guideline developed by the MOL and distributed to the industry. The tire cage or holding device must be suited to the work being done. This would include the size of the tire and the explosive energy to be contained by the cage or device.

As mentioned previously, the MOL has recently amended the Regulation to require the use of a device to prevent injury to a worker whenever work is performed on a multi piece rim.

The OHSA requires employers to provide protective devices and ensure these devices are maintained in good condition. The design of the device must be such that it will protect the worker. A professional engineer would be able to provide such a design.

Ministry
of
Labour

Ministère
du
Travail



Office of the Assistant Deputy Minister
Bureau du sous-ministre adjoint

Operations Division
400 University Avenue
14th Floor
Toronto, ON M7A 1T7
Telephone: (416) 326-7667
Facsimile : (416) 326-7599

Division des opérations
400, avenue University
14^e étage
Toronto ON M7A 1T7
Téléphone: (416) 326-7667
Télécopieur: (416) 326-7599

March 5, 2004

Dr. Bonita Porter
Deputy Chief Coroner of Inquests for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. Porter:

Re: Inquest into the death of Shawn Keith Cooper - Deceased May 7, 2001 Your File Number: Q 2003-52

With reference to the recommendations of the Coroner's Jury regarding the above-mentioned fatal incident, I have received the enclosed report from the Provincial Coordinator of the Mining Health and Safety Program, Operations Division. This report was prepared in co-operation with appropriate staff in the Ministry of Labour.

I have forwarded copies of this report and the recommendations of the Jury to the organizations listed below:

Owner, C.E. Reid and Sons, Sand and Gravel
Chairman, Health and Safety Committee, c/o C.E. Reid and Sons Sand and Gravel
Deputy Minister, Ministry of Training, Colleges and Universities
Assistant Professor, School of Environmental Health, Ryerson Polytechnic University
Lawyer, Toronto Workers' Health and Safety Legal Clinic
Vice President, Prevention, Workplace Safety and Insurance Board
Co-ordinator, Volunteer Activities Industrial Accident Prevention Association
General Manager & CEO, Municipal Health and Safety Association
Librarian, Mines and Aggregates Safety and Health Association
General Manager, Mines and Aggregates Safety and Health Association
Managing Director, Camiro Mining Division
Mining Association of Canada
President, Ontario Mining Association
Deputy Minister, Ministry of Labour

Please let me know if you wish to discuss any aspect of this matter with me or my officials.

Yours truly,

Helle Tosine
Assistant Deputy Minister

**SYNOPSIS OF SIGNIFICANT FACTORS
CONTRIBUTING TO THE DEATH OF**

Shawn Keith Cooper

Deceased May 7, 2001

Reid & Sons Gravel Pit – Goderich

Mr. Cooper was employed by C.E. Reid and Sons Gravel Pit. On May 7, 2001 he was operating a dump truck taking material from the pit to a storage facility. While doing so, he got his truck stuck in soft sand off the traveled driveway. A co-worker saw Mr. Cooper stuck, parked his truck, and started a Cat 930 front-end loader, intending to help pull the truck out of the sand. The loader had previously been reported to have faulty brakes. He approached the front end of the truck that was on a slight decline. Mr. Cooper attached a chain to the front-end of the truck and stood between the truck and the bucket of the front-end loader. As he was putting the chain on the bucket of the front-end loader, the loader's brakes failed causing the loader to roll forward crushing Mr. Cooper between the bucket and the truck. The co-worker backed up the loader and attended to Mr. Cooper. An ambulance was called, and Mr. Cooper was taken to the local hospital where resuscitation was initiated, but attempts to revive Mr. Cooper failed and he was pronounced dead shortly after arriving at the hospital.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Shawn Keith Cooper

**Deceased May 7, 2001
Reid & Sons Gravel Pit/Goderich**

The Ministry of Labour (MOL) has responded to all the recommendations whether they were specifically directed at the MOL or not. The MOL response is meant to guide the chief coroner and provide context for the recommendations.

Re: Recommendation No. 1

"A lockout/tag out program should be used. This would help identify faulty equipment and protect the employees from using it".

Sections 28(1)(c) and (d) of the *Occupational Health and Safety Act* (the Act) specifically requires that workers report faulty equipment. The MOL agrees that lockout/tag out programs should be in place.

Evidence indicated that the loader had been reported to have faulty brakes and if it had been locked out due to being in disrepair the worker would not have been able to use the loader.

Hazardous conditions should be reported immediately to the employer. Section 25(1)(b) of the Act also places a responsibility on the employer to maintain equipment in good order. In addition, Section 105 of the Regulation for Mines and Mining Plants (the Regulation) refers to mobile equipment brakes, testing, and maintenance and inspection procedures for each mobile vehicle.

As noted above, it is essential that workplace parties work in compliance with the Act and Regulation, to help ensure a safe and healthy workplace.

The Mines and Aggregates Safety and Health Association (MASHA), is the safe workplace association responsible for the mining sector. MASHA has developed and is delivering, to the mining industry, an extensive Lock & Tag campaign.

MOL inspectors devote a large portion of their time to inspecting lock and tag hazards in the mining industry. Recently the number of orders written against these hazards has increased due to the targeting initiatives put in place by the MOL.

Re: Recommendation No. 2

“More funding for inspectors or reassessment of the inspection times particularly for previous violators is needed”.

MOL uses a risk-based approach to determine inspection locations. The Ministry analyzes a wide assortment of statistical information and in consultation with the Workplace Safety and Insurance Board (WSIB) and the Mines and Aggregate Safety and Health Association (MASHA) prioritizes where field inspections are to be conducted. The MOL identifies hazardous work practices and workplaces with substandard injury frequencies where inspectors are to pay particular attention.

Previous violators are not specifically targeted unless they fall into the categories mentioned above or it is suspected there is non-compliance in the workplace.

Re: Recommendation No. 3

“Ministry of Labour should review training, workplace safety and maintenance logs of equipment on an annual basis”.

The Ministry agrees that audits need to be done to ensure safety devices are in place, but this is the employer’s responsibility. In addition, the Internal Responsibility System requires all workplace parties to communicate workplace issues. This will contribute to continuous improvement of workplace conditions and will help ensure safety devices are in place.

As indicated above, the Ministry targets under-performing workplaces and hazardous situations and conducts follow-up visits where warranted.

The MOL also agrees that training programs should be audited and monitored on a regular basis and this is addressed in current legislation.

Section 25(2)(a) of the Act requires employers to provide information, instruction and supervision to a worker to protect the health or safety of that worker. All modular training required by section 11 of the Regulation is to be done by qualified trainers.

Training programs must be audited, monitored and documented accurately so there is no doubt as to what training has been received by whom, and when. The monitoring should also include information regarding the trainer.

It should be noted that the legislation is a minimum requirement, and that any enhancements above and beyond that which is required is encouraged. Auditing and monitoring training is good record keeping, and assists both the employer and worker.

Re: Recommendation No. 4

“Mandatory safety orientation should be provided for all new employees and they should complete the modules as soon as possible. Safety modules should be expanded to include a towing vehicle component (including proper wheel blocking) and truck drivers should complete a driver supplementary module. Relevant records should be kept on file”.

MOL legislation, which became effective in July 2001, requires that surface mine workers be trained in the common core modules plus the appropriate specialty modules for the work they are to perform in section 11.2 of the Regulations. One of the specialty modules is for truck drivers. Presently the module does not address towing. The Provincial Coordinator of the Mining Program will bring the matter of towing at surface mines to the attention of the Mining Tripartite committee. This committee developed the common core training programs and includes members from industry, labour, the MOL and Ministry of Training Colleges and Universities.

Employers are encouraged by MOL inspectors to keep training records on file. The written record is proof that the training exists and has been provided.

Re: Recommendation No. 5

“All businesses, regardless of size, need a designated representative to deal with safety issues”.

The legislation specifically requires that at least one health and safety representative be chosen for workplaces with 5 to 19 workers. However workplaces with less than 5 workers are not required to have a representative unless ordered by the Minister, Section 8(2) of the Act.

The role of the representative is to be an advocate to the employer on behalf of the workers. In small workplaces the workers and the employer normally have a closer relationship so that issues can be communicated more quickly and a more immediate resolution is possible.

Recommendation No. 6

“Training should be required for operators of all heavy equipment”.

The Ministry agrees that a trained workforce is a safer workforce. Sections 25(2) and 27(2) of the Act speak about the need to ensure that workers are provided with information and instruction and that they are trained and capable of performing the tasks assigned to them.

The need to provide proof of competence to operate powered equipment would help to ensure that workers are in fact trained, and experienced in the operation of machinery, or any other assigned task. An outside body could issue a certificate, or the employer could provide a record of training. Such training should include hazard identification, both specific to the machinery, and the task at hand. As noted previously, it is the employer and supervisor's responsibility to ensure that workers receive information and instruction to enable them to perform their jobs safely.

Re: Recommendation No. 7

"Refresher training at 3 year intervals needs to occur".

The Ministry agrees that after initial training, follow-up at regular intervals by refresher training and review of safe job performance is essential to any effective training program. Section 11.2 of the Regulation, requires an employer to establish and maintain the legislated modular training programs. Workers must be trained for the work they are doing.

The Mining Tripartite Committee has also recommended periodic reviews of worker training. Although the specific mention of "retraining" is not in legislation, there is an ongoing requirement for employers and supervisors to ensure that workers are aware of hazards and how to rectify or avoid them; and that procedures and programs are in place to protect the health and safety of workers. Training is one way of ensuring that workers are aware and safe. The employer must have a means of determining when refresher training is required whether it is 3 years or even more frequently.

Ministry
of
Labour

Ministère
du
Travail



Office of the Assistant Deputy Minister
Bureau du sous-ministre adjoint
Operations Division
400 University Avenue
14th Floor
Toronto, ON M7A 1T7
Telephone: (416) 326-7667
Facsimile : (416) 326-7599

Division des opérations
400, avenue University
14^e étage
Toronto ON M7A 1T7
Téléphone: (416) 326-7667
Télécopieur: (416) 326-7599

March 19, 2004

Dr. Bonita Porter
Deputy Chief Coroner of Inquests for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. Porter:

Re: Inquest into the death of Phillip H. Fischer - Deceased November 22, 2000 - Your File Number: Q 2003-62

With reference to the recommendations of the Coroner's Jury regarding the above-mentioned fatal incident, I have received the enclosed report from the Provincial Coordinator of the Mining Health and Safety Program, Operations Division. This report was prepared in co-operation with appropriate staff in the Ministry of Labour.

I have forwarded copies of this report and the recommendations of the Jury to the organizations listed below:

- President, Goldcorp Inc.
- Chairman, Health and Safety Committee, c/o Goldcorp Inc.
- Deputy Minister, Ministry of Training, Colleges and Universities
- Technical Specialist, Information Projects, Canadian Centre for Occupational Health and Safety
- Assistant Professor, School of Environmental Health, Ryerson Polytechnic University
- Lawyer, Toronto Workers' Health and Safety Legal Clinic
- Vice President, Prevention, Workplace Safety and Insurance Board
- Co-ordinator, Volunteer Activities, Industrial Accident Prevention Association
- General Manager & CEO, Municipal Health and Safety Association
- Librarian, Mines and Aggregates Safety and Health Association
- General Manager, Mines and Aggregates Safety and Health Association
- Managing Director, Camiro Mining Division
- President, Ontario Mining Association
- Deputy Minister, Ministry of Labour

Please let me know if you wish to discuss any aspect of this matter with me or my officials.

Yours truly,

Helle Tosine
Assistant Deputy Minister

**SYNOPSIS OF SIGNIFICANT FACTORS
CONTRIBUTING TO THE DEATH OF**

Phillip H. Fischer

Deceased November 22, 2000

Goldcorp Inc.

On November 22, 2000 Mr. Fischer, a crusher operator employed at the Red Lake Mine Mill by Goldcorp Inc. was discovered unconscious by a fellow worker, his body wedged between a snub pulley and a conveyor belt. It is believed Mr. Fischer was attempting to clean the snub pulley while the conveyor was still running. He was doing this with a wooden stick that had a nail in one end. He was drawn into the pulley and conveyor belt pinch-point when the conveyor belt/pulley grabbed the stick and the nail caught his glove. He later succumbed to crushing injuries

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Phillip H. Fischer

Deceased November 22, 2000

Goldcorp Inc.

The Ministry of Labour (MOL) has responded to all the recommendations whether they were specifically directed at the MOL or not. The MOL response is meant to guide the chief coroner and provide context for the recommendations.

Re: Recommendation No. 1

“We recommend that the Ministry of Labour review:

- a) their time line for the completion of specialty modules**
- b) their time line for registering the completion of all specialty modules with the Ministry of Training, Colleges and Universities”.**

The MOL agrees that all modules should be completed in a timely manner. At present, the Regulation for Mines and Mining Plants (the Regulation) require the completion of the Basic Common Core within twelve months.

The MOL has presented this issue to both the Mining Legislative Review committee (MLRC) and the Mining Tripartite Committee (MTC).

The MOL develops and implements sector-specific enforcement strategies in order to ensure compliance with applicable legislative requirements. As training requirements are identified in the Inspector targeting strategy, they are a focus of routine inspections. In addition, the Occupational Health and Safety Act (OHSA) requires employers to provide workers with adequate information, instruction and supervision to protect their health and safety.

The employer is also responsible for training employees in the appropriate modules for the work they are doing. They also have the responsibility to register, in a timely manner, the individuals for accreditation with the Ministry of Training, Colleges and Universities (MTCU).

Re: Recommendation No. 2

“We recommend to the Ministry of Labour that a re-certification process be put in place for the Common Core for Basic Mill process Operations”.

The MOL agrees that after initial training, follow-up by refresher training at regular intervals and review of safe job performance is essential to any effective training program. Section 11 (1) (3) (i) of the Regulation requires an employer to establish and maintain Program P810050, Common Core for Basic Mill Process Operations - Mineral Ore. Although specific mention of “retraining” is not in the Regulation, there is an ongoing requirement for employers to ensure that workers and persons in authority over them, are aware of hazards in the work, and as a reasonable precaution, to ensure that procedures and programs are in place to protect the health and safety of workers

The MTC has also recommended periodic reviews of worker training.

Re: Recommendation No. 3

“We recommend that the Mining Regulation be amended to allow Mine Rescue to attend at surface emergencies”.

Under the Regulation, the employer is responsible for establishing and maintaining workplace procedures, which include assigning roles and responsibilities in an emergency.

The manager is responsible for directing emergency crews, whether they are Mine Rescue, firefighters, etc. On the night of this fatal incident the Mine Rescue officer, who is also a volunteer fireman, responded to the emergency call as a fireman with the mine rescue vehicle and was temporarily denied access to the property.

Management and the Mine Rescue organization have since set up a protocol to follow in surface and underground emergencies.

Re: Recommendation No. 4

“We recommend that the Mines assign a dedicated full time Mill Trainer and/or Supervisor to train and maintain accurate records of each employee’s progress”.

Under OHSA, employers must take every precaution reasonable in the circumstances to ensure the safety of the workers. Employers must provide adequate supervision to ensure the health and safety of workers and workers must

be made aware of the hazards in the work they are to perform and how to perform it safely. Section 11 of the Regulation requires employers to establish and maintain training programs; record keeping is an inherent part of maintaining those training programs.

Since the fatal incident, the company has hired a full time mill trainer, who will be responsible for the training and maintenance of the employees' records.

Re: Recommendation No. 5

"We recommend that the Mines ensure that each employee be required to acknowledge they have received and reviewed all policies and procedure pertaining to their job by signing and dating a log provided to them by their Supervisor and/or Trainer".

The MOL agrees that it is critical for all workplace parties to be knowledgeable about policies and procedures pertaining to the workplace. The recommendation for an acknowledgement system that workers have received and reviewed all policies and procedures would help ensure that at a minimum, workers and supervisors are reminded of current practices. Workers must be kept apprised of any and all information essential to ensure their safety in the workplace. The OHSA requires employers to ensure that workers are provided with information and instruction to protect their health or safety, and requires supervisors to advise workers of dangers of which they are aware and, where prescribed, to provide written instructions as to procedures. The OHSA also requires that workers identify and report any hazards to their supervisors.

Ministry
of
Labour

Ministère
du
Travail



Office of the Assistant Deputy Minister
Bureau du sous-ministre adjoint

Operations Division
400 University Avenue
14th Floor
Toronto, ON M7A 1T7
Telephone: (416) 326-7667
Facsimile : (416) 326-7599

Division des opérations
400, avenue University
14^e étage
Toronto ON M7A 1T7
Téléphone: (416) 326-7667
Télécopieur: (416) 326-7599

June 30, 2004

Barry A. McLellan, M.D., FRCPC
Acting Chief Coroner for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. McLellan:

Re: Inquest into the death of Rodney Harten - Deceased April 12, 2002 Your File Number: Q2003-70

With reference to the recommendations of the Coroner's Jury regarding the above-mentioned fatal incident, I have received the enclosed report from the Provincial Coordinator of the Mining Health and Safety Program, Operations Division. This report was prepared in co-operation with appropriate staff in the Ministry of Labour.

I have forwarded copies of this report and the recommendations of the Jury to the organizations listed below:

Technical Specialist, Information Projects, Canadian Centre for Occupational Health and Safety
Assistant Professor, School of Environmental Health, Ryerson Polytechnic University
Lawyer, Toronto Workers' Health and Safety Legal Clinic
Vice-president, Prevention, Workplace Safety and Insurance Board
Coordinator, Volunteer Activities, Industrial Accident Prevention Association
General Manager & Chief Executive Officer, Municipal Health & Safety Association
Librarian, Mines and Aggregates Safety and Health Association
General Manager, Mines and Aggregates Safety and Health Association
Managing Director, Camiro Mining Division
President and Chief Executive Officer, Placer Dome Canada Limited
Mining Association of Canada
President, Ontario Mining Association
Deputy Minister, Ministry of Labour

Please let me know if you wish to discuss any aspect of this matter with me or my officials.

Yours truly,

Helle Tosine
Assistant Deputy Minister

**SYNOPSIS OF SIGNIFICANT FACTORS
CONTRIBUTING TO THE DEATH OF**

Rodney Harten

**Deceased April 12, 2002
Placer Dome (CLA) Ltd – Dome Mine**

Inquest Date: December 10 & 11, 2003

On April 11, 2002 Mr. Harten was working underground operating a scoop tram (LHD) in a long hole stope. While doing so, Mr. Harten was struck by a large piece of rock, which fell from the wall of the stope and fatally injured him. Mr. Harten had been assigned to load ore from a stope using a remote control LHD. This specially developed procedure allowed Mr. Harten to remain in a safe place while the LHD loaded ore from the hazardous area of the stope. It is not known why Mr. Harten decided to operate the LHD manually except to possibly have a better view of the area where ore was being loaded.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Rodney Harten

Deceased April 12, 2002

Placer Dome (CLA) Ltd – Dome Mine

Inquest Date: December 10 & 11, 2003

The Ministry of Labour (MOL) has responded to all the recommendations whether they were specifically directed at the MOL or not. The MOL response is meant to guide the chief coroner and provide context for the recommendations.

Re: Recommendation No. 1

“If there is a *VCARS chapter in the area then legislation be in place to ensure that their services be utilized immediately. This to be the Mine Manager’s responsibility”.

***Victim Crisis Assistance & Referral Service**

The MOL agrees that trained counselling services such as Victim Crisis Assistance & Referral Service should be available for family and friends of victims that may require counselling. Some employers already utilise such services. This type of services would be most beneficial if it was a site-specific arrangement for that workplace and type of incident.

Re: Recommendation No. 2

“Look at the feasibility of installing remote camera on scrooptram so the worker has a clear view of the work area. (Ministry of Labour)”.

Mr. Harten’s work was to operate a remote control scooptram (LHD) to load ore from a stope. Remote control is used so the operator can remotely operate the LHD from a safe location while the LHD is operating in a hazardous area. Some areas where ore must be loaded are very hazardous and there is a risk of rock falling, which may strike workers.

Operators are instructed not to enter the hazardous area. There is however a possibility that the operator cannot see the immediate area where the LHD will be working. In this case, Mr. Harten could not see where the LHD was loading. He left the safe location and manually drove the LHD into the hazardous area where he was struck by falling rock. It is surmised that he may have wanted to get a better look at what had to be loaded. When found by others the LHD was seen to have a large chunk in the bucket. It would have been necessary for Mr. Harten to load or remove this chunk from the loading area before proceeding to load the remainder of the ore from that area. Loading this large chunk without good visibility would have been difficult.

A camera mounted on the LHD to aid the operator in loading is a good idea and the MOL supports the use of this technology. The image taken by the camera is displayed on a monitor at the operator's safe location increasing the operator's perception of the area where loading is taking place. It would allow more effective and efficient loading.

This technology is available and being used in some mines. It is a site-specific decision as to what practice the employer and the workplace parties will utilize to ensure the work is done safely.

The employer is required to take every precaution reasonable in the circumstances for the protection of the worker in addition to providing information and instruction to the worker. This would include the provision of, and instruction in, equipment to safely do work such as loading by remote control.

Ministry
of
Labour

Ministère
du
Travail



Office of the Assistant Deputy Minister
du sous-ministre adjoint Operations Division
Division des opérations
400 University Avenue
14th Floor
Toronto, ON M7A 1T7
Telephone: (416) 326-7667
Facsimile : (416) 326-7599

Bureau

400, avenue University
14^e étage
Toronto ON M7A 1T7
Téléphone: (416) 326-7667
Télécopieur: (416) 326-7599

June 21, 2004

Barry A. McLellan, M.D., FRCPC
Acting Chief Coroner for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. McLellan:

**Re: Inquest into the death of Andre Lamoureux - Deceased September 7, 2000 Your
File Number: Q-2004-17**

With reference to the recommendations of the Coroner's Jury regarding the above-mentioned fatal incident, I have received the enclosed report from the Provincial Coordinator of the Mining Health and Safety Program, Operations Division. This report was prepared in co-operation with appropriate staff in the Ministry of Labour.

I have forwarded copies of this report and the recommendations of the Jury to the organizations listed below:

Technical Specialist, Information Projects, Canadian Centre for Occupational Health and Safety
Assistant Professor, School of Environmental Health, Ryerson Polytechnic University
Lawyer, Toronto Workers' Health and Safety Legal Clinic
Vice President, Prevention, Workplace Safety and Insurance Board
Co-ordinator, Volunteer Activities, Industrial Accident Prevention Association
General Manager & CEO, Municipal Health and Safety Association
Librarian, Mines and Aggregates Safety and Health Association
General Manager Mines and Aggregates Safety and Health Association
Managing Director, Camiro Mining Division
Mining Association of Canada
President, Falconbridge Limited
Canadian Council of Professional Engineers
Executive Assistant, Professional Engineers of Ontario
Director, Canadian Society for Professional Engineers
Deputy Minister, Ministry of Labour

Please let me know if you wish to discuss any aspect of this matter with me or my officials.

Yours truly,

Helle Tosine
Assistant Deputy Minister

**SYNOPSIS OF SIGNIFICANT FACTORS
CONTRIBUTING TO THE DEATH OF**

Andre Lamoureux

**Deceased September 7, 2000
Falconbridge, Kidd Creek Mining Division**

Inquest Date: March 1-2, 2004

On September 2, 2000, a crew of four workers including Mr. Andre Lamoureux, 49, were instructed to repair damaged pipelines in the ramp between the 5300 and 5400 levels at Falconbridge Ltd.'s Kidd Creek mine in Timmins. Mr. Lamoureux began to cut the bolts on a six inch compressed airline clamp using an oxy-acetylene torch, unaware that the pipe was still under pressure. Clamps are used to join lengths of pipe together. Mr. Lamoureux was struck by the pipe and clamp when it blew apart as he was cutting the bolts.

Mr. Lamoureux was transported to Timmins District Hospital, and then flown by air ambulance to Sudbury General Hospital, where he died from his injuries on September 7, 2000

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Andre Lamoureux

**Deceased September 7, 2000
Falconbridge, Kidd Creek Mining Division**

Inquest Date: March 1-2, 2004

The Coroner's Jury endorsed 13 recommendations submitted by Falconbridge (see attached chart). Falconbridge has provided a status report on each of the items, which indicates that all the recommendations have been complied with or are in the process of being addressed. None of these recommendations were directed to MOL.

The MOL supports Falconbridge's actions. There is merit in reviewing them to determine if wider application to other mine operators is advisable. The Mining Legislative Review Committee (MLRC) will conduct the review. MLRC is a bi-partite committee facilitated by the MOL, which advises the Minister of Labour on matters of health and safety in the mining industry. The MLRC routinely advises the Minister on regulation amendments.

In addition to Falconbridge's recommendations, the Coroner's Jury also endorsed the following 2 recommendations submitted by Mrs. Lamoureux's counsel. Both are directed to MOL:

Re: Recommendation No. 1

"Practices regarding the production and distribution of safety alerts should be reviewed to ensure that specific information is delivered directly and expediently to mining operations throughout Ontario when hazards are uncovered in the wake of critical incidents and near misses".

The MOL agrees with the need to publicize the information surrounding critical incidents and near misses. As information is known it is published widely to the mining industry and any other interested parties in a timely manner by either the MOL or by the Mines and Aggregates Safety and Health Association (MASHA).

The timeliness of these publications is dependant upon the progress of the investigation. Information will not be released until all of the information is known to be accurate.

In addition, information regarding the event may be limited if a prosecution may result from the event. Premature release of information may compromise an ongoing investigation and subsequent prosecution.

The MOL and MASHA are committed to releasing as much information as soon as possible in order to prevent a re-occurrence of the critical event or near miss.

Re: Recommendation No. 2

“Procedures should be established to ensure Ministry of Labour follow-up on internal investigations and remedial measures undertaken by employers in the wake of serious incidents, including site follow-up where appropriate”.

The MOL will conduct follow-up inspections when circumstances indicate it is necessary. MOL inspectors investigate all serious incidents. The MOL considers fatalities, critical injuries, and near misses with high potential for injury as serious events. Inspectors will issue orders or take other enforcement measures such as stop work or prosecution as warranted.

In the event of an order, the workplace is required to submit a “Notice of Compliance” (notice). This notice is to be signed by the employer and a member of the joint health and safety committee (JHSC) or health and safety representative if there is no JHSC. The notice is an indication that compliance has been achieved. Should the JHSC member or health and safety representative choose not to sign the notice, the MOL inspector will determine why the notice was not signed and may revisit the workplace. To support the Internal Responsibility System (IRS) the MOL encourages workplace parties to resolve issues but will intervene if the IRS is not working. A follow-up inspection is a form of intervention. The MOL inspector will conduct a follow-up inspection if not satisfied with the actions including any response from the workplace parties. If there is any doubt the workplace will be re-inspected.

Office of the Assistant Deputy Minister
sous-ministre adjoint

Operations Division
400 University Avenue
14th Floor
Toronto, ON M7A 1T7
Telephone: (416) 326-7667
Facsimile : (416) 326-7599

Bureau du

Division des opérations
400, avenue University
14^e étage
Toronto ON M7A 1T7
Téléphone: (416) 326-7667
Télécopieur: (416) 326-7599

February 13, 2004

Dr. Bonita Porter
Deputy Chief Coroner of Inquests for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. Porter:

Re: Inquest into the death of Bryan E. Smith - Deceased April 2, 2001 Your File Number: Q2003-38

With reference to the recommendations of the Coroner's Jury regarding the above-mentioned fatal incident, I have received the enclosed report from the Provincial Coordinator of the Mining Health and Safety Program, Operations Division. This report was prepared in co-operation with appropriate staff in the Ministry of Labour.

I have forwarded copies of this report and the recommendations of the Jury to the organizations listed below:

President, Nelson Granite
Chairman, Health and Safety Committee, c/o Nelson Granite
Deputy Fire Marshall, Ministry of Community Safety (formerly The Ministry of Public Safety and Security)
Commissioner, Ontario Provincial Police, Ministry of Community Safety (formerly The Ministry of Public Safety and Security)
Technical Specialist, Information Projects, Canadian Centre for Occupational Health and Safety
President and Chief Executive Officer, Technical Standards and Safety Authority
President, Ontario Propane Association Incorporated
President and Chief Executive Officer, Canadian Gas Association
Managing Director, Propane Gas Association of Canada Incorporated
Assistant Professor, School of Environmental Health, Ryerson Polytechnic University
Lawyer, Toronto Workers' Health and Safety Legal Clinic
Vice President, Prevention, Workplace Safety and Insurance Board
Co-ordinator, Volunteer Activities Industrial Accident Prevention Association
General Manager & Chief Executive Officer, Municipal Health & Safety Association
General Manager and Chief Executive Officer, Municipal Health and Safety Association
Managing Director, Camiro Mining Division
Mining Association of Canada
Ontario Mining Association

Deputy Minister, Ministry Of Labour

Please let me know if you wish to discuss any aspect of this matter with me or my officials.

Yours truly,

Helle Tosine
Assistant Deputy Minister

**SYNOPSIS OF SIGNIFICANT FACTORS
CONTRIBUTING TO THE DEATH OF**

Bryan E. Smith

Deceased April 2, 2001

Nelson Granite Quarry

Docker Township, Vermillion Bay, Ontario

Mr. Bryan Smith, 38 years of age, employed by Nelson Granite Limited, was fatally injured on April 2, 2001, while working at the Nelson Granite Quarry, Docker Township, Vermillion Bay, Ontario.

Part of Mr. Smith's work involved using a portable steam-generating device (boiler), heated by portable propane torches, to melt ice in drill holes used for blasting. The steam generator (one foot in diameter and one foot long) exploded while Mr. Smith was near the device causing fatal injuries to Mr. Smith.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Bryan E. Smith

Deceased April 2, 2001

**Nelson Granite Quarry
Docker Township, Vermillion Bay, Ontario**

The Ministry of Labour (MOL) has responded to all of the recommendations regardless if they were directed at the MOL or not. The MOL response is meant to guide the Chief Coroner and perhaps put the recommendations into context.

Recommendations 7 & 8 are responded together because the issues are related.

Re: Recommendation No. 1

“Boiler Pressure Vessels Act should be reworded regarding the definition of a low pressure boiler to (9) provide clarity. Chapter B9(1) specifically excludes boilers that are capable of a gas or vapour pressure over 15 pounds”.

The MOL agrees that the definition of a “low pressure boiler” in the Boilers and Pressure Vessels Act (BPVA) that was in place at the time of the death required clarity. Subsequent to the death, the BPVA was repealed and replaced in July 2001 with Regulation 220/01 on Boilers and Pressure Vessels made under the Technical Standards and Safety Act, 2000. The definition of “low pressure boiler” was reworded in the new regulation (“pressure of 15 pounds or less” was replaced with “pressure of 15 psi or less”). The Regulation on Boilers and Pressure Vehicles exempts low pressure boilers with a wetting heating surface of 30 sq. ft. that are intended to be operated at a pressure of 15 psi or less.

Re: Recommendation No. 2

“Designs for shop built, low pressure boiler should be submitted to an engineer for approval. Usage instruction or cautions should be provided with the approval of the engineer. Regular (yearly) inspections should be conducted by the appropriate authority, to ensure design is adhered to. Inspectors should be instructed to watch for such devices onsite with the purpose of instructing in dangers and bringing equipment up to standards, i.e. adding pressure release valves or pressure gauges”.

The MOL agrees that a professional engineer must review designs for shop built low pressure boilers, existing boilers must be regularly examined and usage instruction or cautions must be provided.

The boiler used in this incident was a homemade boiler, deficient in several areas of operation. It did not have a gauge and did not have a pressure release mechanism. The use of such a poorly designed device is in contravention of *the Occupational Health and safety Act* (OHSA), and the Regulations for Mines and mining Plants (Regulations).

The OHSA, section 25(2)(h), requires that the employer must take every precaution reasonable for the protection of the workers. Under OHSA, section 25(2)(a), the employer is responsible to provide information, instruction and supervision to a worker to protect the health and safety of the worker. In addition, OHSA requires the employer to ensure that all required protective devices are provided, maintained and used according to proper procedure. The legislation also requires proper procedures to be written, communicated to workers and carried out by workers.

Section 198(2) of the Regulations for Mines and Mining Plants states that even a steam boiler to which the BPVA does not apply shall be regularly examined for proper and safe condition.

Safe steam generators (boilers) are available. Safe portable steam generators are used for such jobs as melting ice and snow in culverts and for cleaning equipment. They are provided with the following safety features:

- a safety valve that is set for the safe operating pressure and that has the capacity to discharge the flow of steam in order to prevent an explosion.
- a suitable boiler that is designed and welded to safely produce steam at the working pressure, with a reserve factor of safety before any explosion can occur.
- a safe means of using the fuel to heat the boiler so that a fuel explosion or overheating of the boiler is prevented.
- some steam generators must be approved in accordance with regulation (BPV) under the Technical Standards and Safety Act (TSSA).

Re: Recommendation No. 3

“Maintenance and modifications of all equipment should be done only by qualified personnel”.

The MOL agrees that competent personnel should do maintenance and modifications of all equipment. Under section 25 (2) (h) of The OHSA an employer must take every precaution reasonable in the circumstances for the protection of workers. This would include ensuring that adequately trained and competent persons are performing maintenance and modifications on equipment, that the work is done in accordance with good practices, that workers are properly trained and are aware of —possible hazards that may be encountered in doing the work, and in how to recognize and deal with any of these possible hazards.

Employers, supervisors and workers must be committed to work together to eliminate sub-standard and unsafe acts, conditions and practices. The MOL had a study completed on the Internal Responsibility System (IRS). The IRS is the cornerstone for health and safety in Ontario and consists of rights and responsibilities for workplace parties as specified in The OHSA. The study developed a description of IRS and an audit tool to be used by workplaces. The description of a well functioning IRS is where everyone in the workplace takes responsibility for improving the health and safety of the workers.

Re: Recommendation No. 4
“Lock Out” procedures should be followed on equipment that is intended to remain inoperable”.

The MOL agrees that where workers might be injured by inadvertent start-ups, equipment that is intended to remain inoperable shall be locked out. The regulations address this requirement and guidance material has been developed and published for the locking of either electrical or mechanical devices.

Re: Recommendation No. 5
“Tiger torches should be required to have safety features so that they cannot be left unattended, or so that they turn off the flow of propane when the flame goes out, i.e., spring triggers or thermal couplers”.

The MOL agrees that torches should be required to have safety features mentioned by this recommendation and that “homemade” portable steam generators should never be used. Safe steam generators are available and they are provided with a safe means of using the fuel to heat the boiler so that a fuel explosion or overheating is prevented. In order to follow The OHSA and Mining Regulations any portable device for the production of steam should be an approved device that is maintained in a safe condition by following the manufacturer’s instructions. Safe procedures must be developed for using steam generators and workers must be trained in the use of these devices.

Re: Recommendation No. 6
“Public education and awareness regarding the danger potential of low pressure steam vessels should be increased”.

The MOL agrees that public education and awareness regarding the potential danger of “homemade” portable steam generators is required. On April 2001, the MOL issued a letter with a hazard notice regarding “homemade” steam generators that might be found in mining, industrial and construction work places. The same notice was issued to the TSSA (Boilers and Pressure Vessels Program) and to the Mines and Aggregates Safety and Health Association’s Underground Equipment Committee for further distribution.

The MOL recently passed legislation requiring the common basic training of all production workers in a surface mine (Mining Regulations, section 11.2). Trained workers are a key component of a safe workplace.

Re: Recommendation No. 7

“Clear lines of authority should be established at the scene of an accident. Any persons arriving on the scene should be informed of who is in charge at any given time”.

Re: Recommendation No. 8

“Any authority or agency called to the scene of a fatal accident should always file a complete report even if it is discovered that they have no jurisdiction”.

The MOL agrees that it is important that any agency or authority that may have an interest in a workplace incident works co-operatively to ensure that the incident is fully investigated. In furtherance of this objective, the MOL entered into a Memorandum of Understanding with the Technical Standards and Safety Authority (TSSA) establishing an investigations protocol that defines their respective roles and responsibilities.

NOTICES – Confined Space Regulation

294. In this Part,

“acceptable atmospheric levels” means that,

- (a) the atmospheric concentration of any explosive or flammable gas or vapour is less than,
 - (i) 25 per cent of its lower explosive limit, if paragraph 1 of subsection 311 (4) applies,
 - (ii) 10 per cent of its lower explosive limit, if paragraph 2 of subsection 311 (4) applies,
 - (iii) 5 per cent of its lower explosive limit, if paragraph 3 of subsection 311 (4) applies,
- (b) the oxygen content of the atmosphere is at least 19.5 per cent but not more than 23 per cent by volume, and
- (c) the exposure to atmospheric contaminants does not exceed any applicable level set out in a regulation made under the Act and listed in Table 1;

“assessment” means an assessment of hazards with respect to one or more confined spaces in a workplace, as described in section 298;

“atmospheric hazards” means,

- (a) the accumulation of flammable, combustible or explosive agents,
- (b) an oxygen content in the atmosphere that is less than 19.5 per cent or more than 23 per cent by volume, or
- (c) the accumulation of atmospheric contaminants, including gases, vapours, fumes, dusts or mists, that could,
 - (i) result in acute health effects that pose an immediate threat to life, or
 - (ii) interfere with a person’s ability to escape unaided from a confined space;

“cold work” means work that is not capable of producing a source of ignition;

“confined space” means a fully or partially enclosed space,

- (a) that is not both designed and constructed for continuous human occupancy, and
- (b) in which atmospheric hazards may occur because of its construction, location or contents or because of work that is done in it;

“emergency work” means work performed in connection with an unforeseen event that involves an imminent danger to the life, health or safety of any person;

“hot work” means work that is capable of producing a source of ignition;

“lead employer” means an employer who contracts for the services of one or more other employers or independent contractors in relation to one or more confined spaces that are located,

- (a) in the lead employer’s own workplace, or
- (b) in another employer’s workplace;

“plan” means a plan for one or more confined spaces in a workplace, as described in section 299;

“program” means a program for one or more confined spaces in a workplace, as described in section 297;

“purging” means displacing contaminants from a confined space;

“related work” means work that is performed near a confined space in direct support of work inside the confined space.

295. (1) Sections 296 to 299 and 301 to 313 of this Regulation do not apply to emergency work performed by,

- (a) a firefighter as defined in the Fire Protection and Prevention Act, 1997; or
- (b) a person who,
 - (i) holds a certificate under the Technical Standards and Safety Act, 2000 designating him or her as a gas technician, and
 - (ii) is working under the direction of a fire department, as defined in the Fire Protection and Prevention Act, 1997.

(2) A worker described in subsection (1) who performs emergency work shall be adequately protected by,

- (a) personal protective equipment, clothing and devices provided by the worker’s employer;
- (b) training under section 300 provided by that employer; and
- (c) written procedures and other measures developed by that employer.

(3) This Part does not apply to work performed underwater by a diver during a diving operation as defined in Ontario Regulation 629/94 (Diving Operations) made under the Act.

296. (1) This section applies if the workers of more than one employer perform work in the same confined space or related work with respect to the same confined space.

(2) Before any worker enters the confined space or begins related work with respect to the confined space, the lead employer shall prepare a co-ordination document to ensure that the duties imposed on employers by sections 297 to 299, 301 to 304 and 306 to 312 are performed in a way that protects the health and safety of all workers who perform work in the confined space or related work with respect to the confined space.

(3) Without restricting the generality of subsection (2), the co-ordination document may provide for the performance of a duty or duties referred to in that subsection by one or more employers on behalf of one or more other employers, with respect to some or all of the workers.

(4) A copy of the co-ordination document shall be provided to,

- (a) each employer of workers who perform work in the same confined space or related work with respect to the same confined space; and
- (b) the joint health and safety committee or health and safety representative, if any, for each employer of workers who perform work in the same confined space or related work with respect to the same confined space.

297. (1) If an employer's workplace includes a confined space that workers may enter to perform work, the employer shall ensure that a written program for the confined space is developed and maintained in accordance with this Part before a worker enters the confined space.

(2) The program may apply to one or more confined spaces.

(3) The program shall be developed and maintained in consultation with the joint health and safety committee or the health and safety representative, if any.

(4) The program shall be adequate and shall provide for,

- (a) a method for recognizing each confined space to which the program applies;
- (b) a method for assessing the hazards to which workers may be exposed, in accordance with section 298;
- (c) a method for the development of one or more plans, in accordance with section 299;
- (d) a method for general training of workers, in accordance with section 300; and
- (e) an entry permit system that sets out the measures and procedures to be followed when work is to be performed in a confined space to which the program applies.

(5) The employer shall provide a copy of the program to the joint health and safety committee or the health and safety representative, if any.

(6) The employer shall ensure that a copy of the program is available to,

- (a) any other employer of workers who perform work to which the program relates; and
- (b) every worker who performs work to which the program relates, if the workplace has no joint health and safety committee or health and safety representative.

298. (1) Before any worker enters a confined space, the employer shall ensure that an adequate assessment of the hazards related to the confined space has been carried out.

(2) The assessment shall be recorded in writing and shall consider, with respect to each confined space,

- (a) the hazards that may exist due to the design, construction, location, use or contents of the confined space; and
- (b) the hazards that may develop while work is done inside the confined space.

(3) The record of the assessment may be incorporated into an entry permit under section 302.

(4) If two or more confined spaces are of similar construction and present the same hazards, their assessments may be recorded in a single document, but each confined space shall be clearly identified in the assessment.

(5) The employer shall appoint a person with adequate knowledge, training and experience to carry out the assessment and shall maintain a record containing details of the person's knowledge, training and experience.

(6) The assessment shall contain the name of the person who carries out the assessment.

(7) The person shall sign and date the assessment and provide it to the employer.

(8) On request, the employer shall provide copies of the assessment and of the record mentioned in subsection (5) to,

- (a) the joint health and safety committee or the health and safety representative, if any; or
- (b) every worker who performs work to which the assessment relates, if the workplace has no joint health and safety committee or health and safety representative.

(9) The employer shall ensure that the assessment is reviewed as often as is necessary to ensure that the relevant plan remains adequate.

299. (1) Before any worker enters a confined space, the employer shall ensure that an adequate written plan, including procedures for the control of hazards identified in the assessment, has been developed and implemented by a competent person for the confined space.

(2) The plan may be incorporated into an entry permit under section 302.

(3) The plan shall contain provisions for,

- (a) the duties of workers;
- (b) co-ordination in accordance with section 296, if applicable;
- (c) on-site rescue procedures, in accordance with section 303;
- (d) rescue equipment and methods of communication, in accordance with section 304;
- (e) personal protective equipment, clothing and devices, in accordance with section 305;
- (f) isolation of energy and control of materials movement, in accordance with section 306;
- (g) attendants, in accordance with section 307;
- (h) adequate means for entering and exiting, in accordance with section 308;
- (i) atmospheric testing, in accordance with section 310;
- (j) adequate procedures for working in the presence of explosive or flammable substances, in accordance with section 311; and
- (k) ventilation and purging, in accordance with section 312.

(4) One plan may deal with two or more confined spaces that are of similar construction and present the same hazards as identified by the assessment.

(5) The employer shall ensure that the plan is reviewed as often as is necessary to ensure that it remains adequate.

300. (1) Every worker who enters a confined space or who performs related work shall be given adequate training for safe work practices for working in confined spaces and for performing related work, including training in the recognition of hazards associated with confined spaces.

(2) The employer shall appoint a person with adequate knowledge, training and experience to conduct the training.

(3) The employer shall ensure that training under this section is developed in consultation with the joint health and safety committee or the health and safety representative, if any.

(4) The employer shall ensure that training under this section is reviewed, in consultation with the joint health and safety committee or the health and safety representative, if any, whenever there is a change in circumstances that may affect the safety of a worker who enters a confined space in the workplace, and in any case at least once annually.

(5) The employer shall maintain up-to-date written records showing who provided and who received training under this section, the nature of the training and the date when it was provided.

(6) The records may be incorporated into an entry permit under section 302.

(7) Training under this section may be combined with training under section 301.

301. (1) The employer shall ensure that every worker who enters a confined space or who performs related work,

- (a) receives adequate training, in accordance with the relevant plan, to work safely and properly; and
- (b) follows the plan.

(2) The employer shall maintain up-to-date written records showing who provided and who received training under this section, and the date when it was provided.

(3) The records may be incorporated into an entry permit under section 302.

(4) Training under this section may be combined with training under section 300.

302. (1) The employer shall ensure that a separate entry permit is issued each time work is to be performed in a confined space, before any worker enters the confined space.

(2) An entry permit shall be adequate and shall include at least the following:

- 1. The location of the confined space.
- 2. A description of the work to be performed there.
- 3. A description of the hazards and the corresponding control measures.
- 4. The time period for which the entry permit applies.
- 5. The name of the attendant described in section 307.
- 6. A record of each worker's entries and exits.
- 7. A list of the equipment required for entry and rescue, and verification that the equipment is in good working order.

8. Results obtained in atmospheric testing under section 310.
9. If the work to be performed in the confined space includes hot work, adequate provisions for the hot work and corresponding control measures.

(3) Before each shift, a competent person shall verify that the entry permit complies with the relevant plan.

(4) The employer shall ensure that the entry permit, during the time period for which it applies, is readily available to every person who enters the confined space and to every person who performs related work with respect to the confined space.

303. (1) The employer shall ensure that no worker enters or remains in a confined space unless, in accordance with the relevant plan, adequate written on-site rescue procedures that apply to the confined space have been developed and are ready for immediate implementation.

(2) Before a worker enters a confined space, the employer shall ensure that an adequate number of persons trained in the matters listed in subsection (3) are available for immediate implementation of the on-site rescue procedures mentioned in subsection (1).

(3) The persons shall be trained in,

- (a) the on-site rescue procedures mentioned in subsection (1);
- (b) first aid and cardio-pulmonary resuscitation; and
- (c) the use of the rescue equipment required in accordance with the relevant plan.

304. (1) The employer shall ensure that the rescue equipment identified in the relevant plan is,

- (a) readily available to effect a rescue in the confined space;
- (b) appropriate for entry into the confined space; and
- (c) inspected as often as is necessary to ensure it is in good working order, by a person with adequate knowledge, training and experience who is appointed by the employer.

(2) The inspection under clause (1) (c) shall be recorded in writing by the person, and the record of the inspection may be incorporated into the entry permit under section 302.

(3) The employer shall establish methods of communication that are appropriate for the hazards identified in the relevant assessment, and shall make them readily available for workers to communicate with the attendant described in section 307.

305. The employer shall ensure that each worker who enters a confined space is provided with adequate personal protective equipment, clothing and devices, in accordance with the relevant plan.

306. The employer shall, in accordance with the relevant plan, ensure that each worker entering a confined space is adequately protected,

- (a) against the release of hazardous substances into the confined space,
 - (i) by blanking or disconnecting piping, or
 - (ii) if compliance with subclause (i) is not practical in the circumstances for technical reasons, by other adequate means;
- (b) against contact with electrical energy inside the confined space that could endanger the worker,
 - (i) by disconnecting, de-energizing, locking out and tagging the source of electrical energy, or
 - (ii) if compliance with subclause (i) is not practical in the circumstances for technical reasons, by other adequate means;
- (c) against contact with moving parts of equipment inside the confined space that could endanger the worker,
 - (i) by disconnecting the equipment from its power source, de-energizing the equipment, locking it out and tagging it, or
 - (ii) if compliance with subclause (i) is not practical in the circumstances for technical reasons, immobilizing the equipment by blocking or other adequate means; and
- (d) against drowning, engulfment, entrapment, suffocation and other hazards from free-flowing material, by adequate means.

307. (1) Whenever a worker is to enter a confined space, the employer shall ensure that an attendant,

- (a) is assigned;
- (b) is stationed outside and near,
 - (i) the entrance to the confined space, or
 - (ii) if there are two or more entrances, the one that will best allow the attendant to perform his or her duties under subsection (2);
- (c) is in constant communication with all workers inside the confined space, using the means of communication described in the relevant plan; and
- (d) is provided with a device for summoning an adequate rescue response.

(2) The attendant shall not enter the confined space at any time and shall, in accordance with the relevant plan,

- (a) monitor the safety of the worker inside;
- (b) provide assistance to him or her; and
- (c) summon an adequate rescue response if required.

308. An adequate means for entering and exiting shall be provided for all workers who enter a confined space, in accordance with the relevant plan.

309. If there is a possibility of unauthorized entry into a confined space, the employer shall ensure that each entrance to the confined space,

- (a) is adequately secured against unauthorized entry; or
- (b) has been provided with adequate barricades, adequate warning signs regarding unauthorized entry, or both.

310. (1) The employer shall appoint a person with adequate knowledge, training and experience to perform adequate tests as often as necessary before and while a worker is in a confined space to ensure that acceptable atmospheric levels are maintained in the confined space in accordance with the relevant plan.

(2) If the confined space has been both unoccupied and unattended, tests shall be performed before a worker enters or re-enters.

(3) The person performing the tests shall use calibrated instruments that are in good working order and are appropriate for the hazards identified in the relevant assessment.

(4) The employer shall ensure that the results of every sample of a test are recorded, subject to subsection (5).

(5) If the tests are performed using continuous monitoring, the employer shall ensure that test results are recorded at adequate intervals.

(6) The tests shall be performed in a manner that does not endanger the health or safety of the person performing them.

(7) In this section,

“sample” means an individual reading of the composition of the atmosphere in the confined space;

“test” means a collection of samples.

311. (1) This section applies only in respect of atmospheric hazards described in clause (a) of the definition of “atmospheric hazards” in section 294.

(2) The employer shall ensure that this section is complied with, by ventilation, purging, rendering the atmosphere inert or other adequate means, in accordance with the relevant plan.

(3) The employer shall ensure that no worker enters or remains in a confined space that contains or is likely to contain an airborne combustible dust or mist whose atmospheric concentration may create a hazard of explosion.

(4) The employer shall ensure that no worker enters or remains in a confined space that contains or is likely to contain an explosive or flammable gas or vapour, unless one of the following applies:

1. The worker is performing only inspection work that does not produce a source of ignition. In the case of an explosive or flammable gas or vapour, the atmospheric concentration is less than 25 per cent of its lower explosive limit, as determined by a combustible gas instrument.
2. The worker is performing only cold work. In the case of an explosive or flammable gas or vapour, the atmospheric concentration is less than 10 per cent of its lower explosive limit, as determined by a combustible gas instrument.
3. The worker is performing hot work. All the following conditions are satisfied:
 - i. In the case of an explosive or flammable gas or vapour, the atmospheric concentration is less than 5 per cent of its lower explosive limit, as determined by a combustible gas instrument.
 - ii. The atmosphere in the confined space does not contain, and is not likely to contain while a worker is inside, an oxygen content greater than 23 per cent.
 - iii. The atmosphere in the confined space is monitored continuously.
 - iv. The entry permit includes adequate provisions for hot work and corresponding control measures.
 - v. An adequate alarm system and exit procedure are provided to ensure that workers have adequate warning and are able to exit the confined space safely if either or both of the following occur:
 - A. In the case of an explosive or flammable gas or vapour, the atmospheric concentration exceeds 5 per cent of its lower explosive limit.
 - B. The oxygen content of the atmosphere exceeds 23 per cent by volume.

(5) Subsections (3) and (4) do not apply if,

- (a) the atmosphere in the confined space,
 - (i) has been rendered inert by adding an inert gas, and
 - (ii) is monitored continuously to ensure that it remains inert; and
- (b) a worker entering the confined space uses,
 - (i) adequate respiratory protective equipment,
 - (ii) adequate equipment to allow persons outside the confined space to locate and rescue the worker if necessary, and
 - (iii) such other equipment as is necessary to ensure the worker's safety.

(6) The equipment mentioned in subclauses (5) (b) (i), (ii) and (iii) shall be inspected by a person with adequate knowledge, training and experience, appointed by the employer, and shall be in good working order before the worker enters the confined space.

312. (1) This section applies only in respect of atmospheric hazards described in clause (b) or (c) of the definition of “atmospheric hazards” in section 294.

(2) If atmospheric hazards exist or are likely to exist in a confined space, the confined space shall be purged, ventilated or both, before any worker enters it, to ensure that acceptable atmospheric levels are maintained in the confined space while any worker is inside.

(3) If mechanical ventilation is required to maintain acceptable atmospheric levels, an adequate warning system and exit procedure shall also be provided to ensure that workers have adequate warning of ventilation failure and are able to exit the confined space safely.

(4) If compliance with subsection (2) is not practical in the circumstances for technical reasons,

- (a) compliance with subsection (3) is not required; and
- (b) a worker entering the confined space shall use,
 - (i) adequate respiratory protective equipment,
 - (ii) adequate equipment to allow persons outside the confined space to locate and rescue the worker if necessary, and
 - (iii) such other equipment as is necessary to ensure the worker's safety.

(5) The equipment mentioned in subclauses (4) (b) (i), (ii) and (iii) shall be inspected by a person with adequate knowledge, training and experience, appointed by the employer, and shall be in good working order before the worker enters the confined space.

313. (1) The employer shall retain every assessment, plan, co-ordination document under section 296, record of training under subsection 300 (5) or 301 (2), entry permit under section 302, record of an inspection under subsection 304 (2) and record of a test under section 310, including records of each sample, for the longer of the following periods:

1. One year after the document is created.
2. The period that is necessary to ensure that at least the two most recent records of each kind that relate to a particular confined space are retained.

(2) If section 296 applies, the documents described in subsection (1) shall be retained by the employer responsible for creating them.