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Hell's History: The USW's Fight to Prevent Workplace Deaths and Injuries from the 1992 Westray Mine, By Tom Sandborn (2016) Toronto: United Steelworkers/Metallos, 73 pages. ISBN-978-0-9958437-0-7

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d'une pensée ouverte au renouvèlement théorique. Comme le note Borzeix dans son texte, « adopter le prisme de l'activité [fera] bouger la sociologie du travail ».

Note

1 Eckert, Henri et Mircea Vultur, (2016) « Activité et circonstances de l'activité », *Sociologie et Sociétés*, XLVIII (1), p. 5-12.

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Hell's History: The USW's Fight to Prevent Workplace Deaths and Injuries from the 1992 Westray Mine

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The *Oxford English Dictionary* defines an accident as: "Something that happens by chance or without expectation; an event that is without apparent or deliberate cause." Most incidents resulting in injury or death in the workplace are referred to as "accidents." Yet anyone who has studied reports of investigations of workplace fatalities knows that they are not "accidents", as defined in the dictionary. These investigations normally demonstrate that fatalities were the result of a series of errors and deliberate decisions, often the result of management policies that determine the culture of the workplace.

On May 9, 1992, a methane gas explosion killed 26 coal miners in the Westray Mine, located in Pictou County, Nova Scotia. Subsequent investigations of the explosion revealed multiple deliberate actions led to the explosion. No manager, no supervisor, no inspector suffered any penalty or punishment for the explosion. This slender volume describes the efforts of the United Steelworkers to establish a stronger legal framework for holding persons responsible for events such as the Westray explosion accountable for their actions (or inactions).

The Westray tragedy illustrates the number of factors that contribute to fatal events. The mine was developed in an area well known for dangerous conditions for miners. Prominent federal and provincial politicians promoted the project, located in an area where jobs were scarce. When private investors were reluctant to develop the project, the provincial power corporation agreed to buy much of the mine's output for 15 years at a fixed price. The provincial government loaned Curragh Resources, the mine owner, $12 million to assist in the development, and the federal government guaranteed a loan to the company. When the mine began operations, provincial regulators ignored frequent safety violations. Sensors that measured gas levels in the mine were disabled. Common precautions to reduce dangerous dust levels in the mine were not implemented. In short, Westray was not an accident. Miners died because of deliberate decisions by corporate and political leaders.

When the facts surrounding the tragedy became known, pressures to hold Curragh Resources and its senior managers accountable grew. An inquiry by a provincial judge produced a detailed report explaining how the explosion was virtually inevitable. Criminal charges were laid and civil suits initiated against the company and its executives. Ultimately, all of these efforts failed.

This failure of the regulatory framework for workplace health and safety caused labour groups, especially the United Steelworkers, which was seeking to represent the miners, to lobby for amendments to the *Criminal Code* to cover negligence leading to workplace injury and death, a recommendation of the Westray inquiry. The union, supported by the New Democratic Party and a private member's bill tabled by Peter MacKay, the Conservative MP whose riding included the Westray site, achieved its goal in 2003, when the *Westray Act* was passed by Parliament.

Unfortunately, the *Act* did little to change the culture of observance of work-

place safety regulations or making senior managers responsible for violations of those regulations. The number of workplace fatalities in Canada, about 1000 per year, did not decline appreciably. Since enactment of the law, there have been less than 10 convictions or guilty pleas for violations. Only one resulted in the offender serving a jail sentence, according to the best evidence available. None involved senior management. Perhaps 18 to 20 charges have been laid against corporations. The book describes other workplace fatalities in British Columbia and Ontario, which occurred after basic safety principles were not observed. By September 2016, charges were pending in two cases.

The author outlines effort by the Steelworkers Union to persuade members of the justice system, including police forces and crown prosecutors to act on evidence of negligence causing deaths in the workplace, with limited success.

Any reader of this book will share the author's sense of outrage at the number of workplace deaths in Canada and governments' lack of interest in using the tools available to reduce the death toll. One might also ask why the acceptance of tragedies in mines, sawmills and construction sites persists and why the *Westray Act* has not had greater impact.

One answer is the high standards for conviction under the *Criminal Code*. The Crown must prove beyond a reasonable doubt that the accused was responsible for the events causing death. Senior managers are typically adept at shifting the blame for operational errors in their organizations.

The regulatory framework for occupational safety outside of the *Criminal Code* is complex. Every province has workplace safety legislation that provides for fines or other penalties for violations of safety regulations. In the case of Westray, prosecution under the provincial safety legislation was delayed pending the outcome of the judicial inquiry and efforts to bring charges of criminal negligence. As a result, both proceedings fell apart, and the responsible parties escaped any punishment. In British Columbia, the investigation of a fatal explosion in a sawmill by safety authorities impeded efforts to lay criminal charges.

Finally, successful prosecutions for white-collar crime are rare in Canada. One thinks of the largest stock fraud in Canadian history, the Bre-x Mine promotion, where no one was ever convicted, though two senior managers moved to Caribbean. Two senior managers of Curragh Resources face prosecution if they return to Nova Scotia.

Did the Westray miners die in vain? Perhaps, but the efforts of the United Steelworkers, the miners' families and other activists have produced a few successes. One lesson of this book and the story it tells is that a concerted effort is necessary to attitudes towards workplace deaths. The sequence of events leading to the Westray tragedy could be reversed. For example, senior politicians promoted Westray, with tragic results. If senior politicians show leadership in eliminating industrial accidents, the number of fatalities will fall. Companies with a record of safety violations should not be eligible for government contracts. Community organizations should consider the role of senior managers in tolerating unsafe practices when honouring them. Clifford Frame, the president of Curragh Resources, had managed other companies in the past with poor safety records and government support. He was named "Miner of the Year," by the Canadian Mining Association. The independence of workplace inspectors should be protected. At Westray, inspectors' reports of hazards were ignored.

The 25th anniversary of the Westray tragedy, commemorated in May 2017, should provide renewed impetus to attack the basic causes of this and other preventable "non-accidents".

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