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December 11, 2008

Endless Inquest Misses the Point

In August 2000 an explosion in the Hudson Bay Mining and Smelting smelter killed one worker, Steve Ewing, and injured a dozen more. Many of those who survived the explosion bear physical and psychic scars to this day. Some of them have never been able to return to work.

In 2001, the company pleaded guilty to keeping an unsafe workplace and was fined $150,000. Because the company entered a guilty plea, the court proceedings were brief and, to workers of Flin Flon, unsatisfying. Their unions had been calling for a provincial inquiry into the disaster, but were forced to settle for a more limited inquest, headed by then provincial court judge Robert Cummings.

The inquest commenced hearings in January 2004. Incredibly, the hearings did not wrap up until this fall. The delay was the result of a series of lengthy court battles over the company's right to gain access to transcripts of pre-inquest interviews that the crown attorney conducted with smelter workers.

The judge's report, released at the end of October, concluded that the explosion was unforeseeable and that the company's planning, management, and safety practices were acceptable. Given that the company had adopted new practices—and might even close the smelter down—Cummings said that it was unlikely that such a disaster would occur again.

Upon reading the report one of the injured workers commented, "it was like a kick in the teeth." Why would workers be so angered by the ruling?

Answering that question requires a bit of background. The explosion took place during the smelter shutdown, an event that used to take place on an annual basis, but since the 1990s occurred approximately every three years. During the shutdown, the smelter furnace is drained, the burners turned off, and the brick structure that forms the smelter's outer shell is knocked down. As part of the process, workers hose down the upper part of the smelter structure so that falling dirt and ash does not injure the eyes of workers, who later rebuild the smelter shell. It is unclear for how long the wash-down has been a part of the shutdown process, but management witnesses maintained it was a longstanding practice.

There was general agreement among witnesses that in 2000 water from the wash-down managed to pierce the crust that forms on the top of the furnace bath and come into contact with molten metal, precipitating a series of deadly explosions. It is also the case that none of the people involved in planning the shutdown believed that the wash-down presented a risk.

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Other evidence presented at the inquest supports the following three points:

1) Planning was inadequate

Since a number of senior supervisors had retired since the last shutdown, the shutdown coordinator for 2000 decided to develop a shutdown manual. However, there was not time to complete the manual prior to the shutdown. The company did not delay the shutdown until the manual was completed.

Even in its incomplete form, the shutdown manual was not prepared in keeping with the company's own job safety program, which required hazard analysis for all tasks. The company explanation for ignoring the program was "We didn't have the resources to do it all."

In 2006, the company undertook a far more extensive planning process prior that year's shutdown, which did not take place until the manual was complete. In the words of a management witness in 2006, as compared to 2000, "we had the time, the resources to do it the right way."

In 2000 company planners did not examine the implications of planned changes in the shutdown process. It was going to be necessary to drain the furnace to as low a level as possible to allow new equipment, intended to speed up the tear-down process, into the furnace. As a result, the content of the bath changed, resulting in a thin crust which solidified at a slower than anticipated rate.

2) The explosion was predictable and preventable

The expert witness evidence presented to the inquest did not suggest that this sort of explosion was unknown to engineers or scientists—or industry. They have occurred in other plants with similar, tragic results.

The supervisors of previous shutdowns carefully controlled the amount of water that fell on the furnace during wash-down. The inquest was told that these supervisors knocked monitoring holes in the furnace and if they observed water building up in the furnace they would stop the process until the water evaporated. In 2000 numerous people, including supervisors, saw water in the furnace but did, being unaware of the risk, not stop the process.

Senior management rejected the shutdown coordinator's request to bring back experienced, retired supervisors for the shutdown. Had they been on the job that night, the explosion might well have been prevented.

3) The supervisors did not receive adequate instruction or preparation

On the night of the explosion, responsibility for supervising the wash-down was reassigned without consideration for the fact that the new supervisor had only worked one wash-down, had received no training in any risks associated with the wash-down and had not read the draft manual wash-down section. During the course of the evening of the shutdown, the supervisors were not required to monitor the composition of the metals in the furnace bath, the temperature of the bath, or the amount of water in the bath.

All of these shortcomings constitute a failure on management's part to put safety ahead of profit. If the shutdown were delayed until a plan was in place, if the experienced workers had been recalled, a decision might have been made to move to a new way to remove the dust (which is what was done in 2006) or a to delay the wash-down until it was clear that the surface of the furnace bath provided was solid and could not be penetrated by the water.

Small wonder workers feel as if they have been kicked in the head by the judge.

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