ALBERTA

Report to the Minister of Justice and Solicitor General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court

in the City (City, Town or Village) of Fort McMurray (Name of City, Town, Village), in the Province of Alberta,

on the 16th day of June, 2014 (year), (and by adjournment

on the 17th day of June, 2014 (year)),

before Stephanie A Cleary, a Provincial Court Judge,

into the death of Adam Piercey (Name in Full) 26 (Age)

of Fort McMurray (Residence) and the following findings were made:

Date and Time of Death: May 27, 2009

Place: Edmonton, Alberta

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *The Fatality Inquiries Act*, Section 1(d)).

Sequelae of Blunt Chest Trauma

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *The Fatality Inquiries Act*, Section 1(h)).

Accidental

Circumstances under which Death occurred:

To determine the cause, manner and circumstances under which Adam Piercey's death occurred, the Court heard from over a dozen witnesses over 2 days, and reviewed approximately two thousand pages of exhibits.

Adam Piercey died in an unfortunate workplace incident involving a crane he had been operating at his workplace, Roofmart Alberta Inc (Roofmart), in Fort McMurray, Alberta, on May 21, 2009.

Adam PIercey was employed as a crane operator by Roofmart in February 2009. He was hired by Carolyn Tuffin, who was then the local branch supervisor. Ms. Tuffin was not a mechanic or a person with any equipment training, but rather was responsible for local personnel matters, administration, ordering supplies, inventory control and bank reconciliations – anything that would be involved in the local running of the business. Roofmart employed Sean Justus as the company's main safety person, and he ensured the safety policies were in place at the local branch. These, as they existed at the time, were all available at the branch although they may not have been explored in detail at the time of Adam's hiring. At the time he was hired, Adam provided a resume to Ms. Tuffin and she sent it to Roofmart's personnel office in Calgary his hiring was approved. Adam signed an employment contract that required him to follow all of the company's policies.

At the time he was hired, Adam Piercey had successfully completed a 2-year Certificate in Crane Operation course at the College of the North Atlantic in Newfoundland and was awarded his certificate in May of 2004. He had also worked in the Red Deer, Alberta, area running cranes on oil rigs for three years prior to being hired by Roofmart.

On May 21, 2009, Adam Piercey was at work at Roofmart, doing deliveries of products for the company. Kierann Greer, one of the young women who worked at the business as a part-time office clerk and had been there for a year, went out on a delivery with him. As she testified, she went on the delivery so that she could understand what happened on that side of the business. Ms. Greer was, at best, company for Adam, as he did all the work from picking up the shingles at the warehouse with a forklift and putting them on the truck to putting shingles up on the roof with the crane. In spite of the fact that he was obviously very busy that morning, Adam took care to ensure that Ms. Greer had every opportunity to watch what he was doing. He put a harness on her and assisted her in coming up to the roof so she could sit and watch while he moved the crane with a remote control to lift the shingles up to the roof. She watched him setting up the crane's outriggers and supporting them with blocks underneath. Ms. Greer noticed that a subsequent attempt to lift a load of shingles was taking longer than the first and saw a "waterish" substance on the ground, obviously leaking from the crane. She was disturbed by this but Adam assured her it would be an "easy" fix, requiring only tightening a screw and would take five minutes.

Adam then called the Roofmart office and spoke to Ms. Tuffin. He told her what was happening and said that he would make his second delivery of shingles to the a job site but that he would not use the crane to lift them onto that site's roof as it required a repair and would not be safe. That delivery was conducted, then Adam and Ms. Greer returned to the office. Ms. Greer asked him if there was anything else that she could help him with but he told her that "it was his truck and he would take care of it."

Ms. Greer recalled Adam and Ms. Tuffin discussing the situation with the crane at the office. She remembered Adam looking for allen keys or wrenches to conduct the repair. Ms.Tuffin testified that she advised Adam that she could make an appointment for the crane to be serviced but that he was adamant that he could fix it and that it would be a "three second job", only requiring allen keys that were not on site at Roofmart. Finally, at his insistence, Ms. Tuffin attending the local

Canadian tire and purchased two sets of allen wrenches, both imperial and metric. Ms. Greer recalled that when she returned with the allen wrenchs, Ms. Tuffin asked Adam "are you sure you are okay with this – are you sure that you can do this?" and his reponse as "Yeah, I'm fine!" He then departed the office area, presumably to conduct the repair on the crane.

Another employee had gone to pick up lunch and when that person returned Ms. Tuffin sent Reginald Chafe, the warehouse supervisor, to get Adam. By that time Adam had been out of communication with anyone in the office for 30 minutes or more. Mr. Chafe discovered Adam pinned within the crane's apparatus and came running into the office frantically. Ms. Greer, trained in first aid, ran to Adam's assistance and found him dangling in the boom truck in the yard with his arms hanging out. She attempted to take his pulse but was unsure if what she felt was his pulse or hers. He was otherwise unresponsive and it was obvious that given the nature of the equipment crushing him that there was nothing she could do to free him from it. There was what turned out to be hydraulic fluid all over the ground.

The employees waited what must have seemed to them like an eternity for ambulances, fire trucks and police to arrive, although it is apparent this really only took an extremely short time.

When emergency responders arrived, Adam was still trapped in the equipment and was found to possibly have a weak pulse but was otherwise unresponsive. The other employees had remained with him but were obviously distraught and were ushered away. Adam appeared to the paramedics to be completely unconscious and lifeless. He was not moving or breathing, and his pulse was so weak that it might even have been a phantom pulse in one of the paramedic's own fingertips that he felt as he looked desperately for a pulse in his patient. The rescue fire truck made efforts to attempt to start extricating Adam after an attempt to manually move the crane with its own hydraulics was unsuccessful, and more hydraulic fluid spilled out. There was no ability to provide Adam any medical treatment such as ventilation given his position within the equipment. There was difficulty using the spreaders to open the equipment so eventually a hydraulic boom had to be used. Given the difficult situation, although it was apparent that firefighters were working frantically to free him, it took approximately 10 minutes or slightly more to accomplish this.

As soon as the equipment moved, Adam dropped down between the rails of the crane, but the responders were able to grab him and guide him onto a spine board. He was apparently badly injured even at first glance. He was covered in hydraulic fluid and had suffered a large amount of bruising to his right side and trauma to his neck area. He had no pulse, nor was his chest rising or were there any lung sounds. His lips were blue indicating that he was not getting sufficient oxygen.

Nonetheless he was intubated and given an IV in the ambulance and at 1:43 pm the ambulance was on the way to the hospital. The paramedics had difficulty intubating him and obtaining a viable airway but they were eventually able to do this and began trying to provide him oxygen by bag and performed CPR. The intravenous line provided him drugs that would hopefully assit in helping his heart to start functioning

Sadly, during transport to the hospital there were no positive changes – there was no response to the medication provided, no sounds that air was getting into his lungs in spite of the intubation, no electrical activity in his heart, and the symptoms of lack of oxygen only got worse. It took only 4 minutes to arrive at the Northern Lights Regional Hospital, where the emergency medical team took over caring for Adam.

At the hospital, chest tubes were inserted and cardiac support was continued and eventually spontaneous circulation returned, although Adam did not regain consciousness. He became stable enough that there was some hope that with further intervention a positive outcome might be achieved. Adam was transported by fixed wing aircraft with advanced life support to the University

of Alberta Hospital in Edmonton where he was cared for aggressively over 6 days. There were no signs of recovery and on the morning of Wednesday, May 27, 2009, it was decided in consultation with his family that aggressive care would be discontinued. At 9:00 pm on May 27, 2009, Adam Piercey was declared deceased.

A full Occupational Health and Safety investigation was conducted, and as a result charges against Roofmart were laid.

The Crane in question, a Hiab, was sold by AR Williams to Roofmart. It was serviced regularly and certified on a yearly basis. This would not have precluded the crane requiring maintenance or repair from time to time, as would be expected with any machine that was in regular use. A mechanical inspection performed after Adam's death revealed that there had likely been some problem parking the crane which damaged a pin at the rest located on the inner boom, close to the top of the column. This likely caused the "small leak" that Adam was attempting to fix. However, Mr. Mark Salmon, the experienced mechanic who inspected the crane, advised that when the allen wrenches were used to loosen the screws attaching the inner boom to the load holding valve, a discharge of hydraulic fluid occurred and this caused the boom, which was elevated at the time the maneuver was performed, and which is very heavy indeed, to drop very quickly. Mr. Salmon testified that the proper way to attempt to repair the crane in such circumstances (where it could not be folded up due to the problem causing the smaller hydraulic leak) would have been to either lay the boom in a horizontal position or otherwise support it in a fashion that would prevent it from moving. As Mr. Salmon pointed out, legislation in the Province of Alberta provides that this type of maintenance may only legally be carried out by a mechanic with both crane experience and experience with this particular model of crane. He testified that had a customer contacted him or the company he then worked for, the customer would have been directed to bring the crane in for repair.

Bradley Hillier, an apprentice Crane operator working for Roofmart, spent 3 days working closely with Adam in Fort McMurray to familiarize him with daily operations of the business. He understood Adam to be a fully qualified, journeyman crane operator, just as his journeyman mentor, Mr. Charles Boyer, was. Adam spoke often of his previous experience. Mr. Hillier found him to "absolutely" be competent in the operation of the crane. During his time working closely with Adam, Mr. Hillier obviously saw nothing that gave him concern and indeed he was shocked to learn of Adam's death and the cause for it. Mr. Hillier, who was then still an apprentice working under another journeyman at Roofmart, told the court that he would never do any work on a crane. He said that in his classroom training they were taught to take a crane in for service by a qualified mechanic if there were ever any difficulty with it.

Mr. Charles Boyer, an experienced journeyman crane operator employed with Roofmart, gave very helpful evidence to the inquiry. He was Bradley Hillier's mentor, as he was a journeyman and Mr. Hillier was still an apprentice. He met Adam once, and spoke to him over the phone about some small difficulty that he was having with the crane's outriggers. He said that Adam figured that problem out and that everything was going well. He inquired of Adam when they met whether or not he was experienced using these types of cranes and Adam told him he "had a ticket." Mr. Boyer concluded that Adam was a journeyman operator like himself and saw nothing to contradict that conclusion.

He described for the court the very minimal type of maintenance that even a journeyman operator would be permitted to do on the equipment in question. It was abundantly clear that the repair undertaken by Adam was well outside the scope of permissible maintenance for an operator, and was not something that Mr. Boyer would ever have contemplated undertaking himself. Mr. Boyer described the safety procedures at Roofmart in place at the time of the incident as "very good" but said that there were some positive changes in terms of safety practices after Adam's death. He

described this as an "improvement" because, as he said "all safety improvements help with industry."

Mr. William Graham, a journeyman crane operator, was employed with Roofmart as a sales representative at the time of the incident. He was the employee who attempted to assist emergency services with by using the crane's own system to open it to free Adam. He was obviously deeply affected by the experience.

Mr. Graham had previously been the branch manager and, at the time of giving evidence, seemed to harbor some resentment as to the course his career took towards the end of his time with the company. He testified that Adam had applied twice to him for a position at Roofmart and that he "discouraged it". He said that at the time this was because Adam was of slight build (although he himself is not a big man), and that he did not have sufficient experience. He said that he would have been prepared to entertain taking him on as an apprentice. He professed that he was "surprised" when Adam showed up as an employee. It was apparent from Mr. Graham's testimony that around the time of Adam's death there was some tension between Mr. Graham and at least local management at Roofmart. He said that he offered to assist Adam but was told by his head office to "stand down" which he said was because of the "conflict" between himself and the successor to his position, Ms. Tuffin. He said that he would have monitored Adam very closely and would have instructed him not to conduct any repairs on the crane. He said that he had concerns about Adam's training and that he brought those to the attention of management but that they "thought he was making a mountain out of a molehill."

With all due respect to Mr. Graham, I found his description of Adam Piercey to be rather condescending, and not to be an accurate assessment of Adam's skills and abilities. He was unaware of Adam's previous experience on the oil rigs. I suppose it is to be expected in such a dreadful set of circumstances as a workplace death of an employee that both hindsight and an individual's personal perception of the employer might colour how they see things. I accept that Mr. Graham's opinions on his own ability to have somehow prevented this incident are honestly held. However, journeyman crane operators ought not to need in depth training and monitoring by another journeyman. One might have expected that a new hire into that position (not as an apprentice), would have been given access to the company's safety policies as Adam was, and some orientation to the company's procedures, as Adam was. While I accept that Mr. Graham was an honest witness, I find that it would be a stretch at best to conclude that had he would have closely monitored and trained Adam in crane operations had he been in charge when Adam was hired. He said himself that journeymen were given only an orientation, not ongoing monitoring in the operation of the equipment they were hired to operate. Indeed it was clear that even experienced apprentices are capable and legally permitted to operate equipment with minimal supervision that is not even required to be on site at all times.

Had Mr. Graham, or indeed any other journeyman crane operator, been present when Adam set about trying to make the repair to the crane, they might well have reminded him of the very basic rule that such repairs ought only to be undertaken by a qualified mechanic. However, it is also clear from the evidence that in other workplaces this basic rule was often ignored. So, such a conclusion is speculative at best, and does not reveal any failing on the part of Roofmart, as there would be no need to have a journeyman be supervised at all times by another journeyman. It is a sad reality that in many workplace deaths, the smallest intervening incident in a long chain would have resulted in a completely different outcome.

It remains bit of a mystery whether or not Adam was "legally" qualified to operate a crane in Alberta. Following his death a search of Alberta records did not reveal a journeyman's certificate. However, he had completed all the classroom work required to enter the apprenticeship program and certainly had enough hours in his prior employment to write the required exams. He represented himself as a journeyman. Even his family was not entirely certain if he had taken the

exams. There does appear to have been a disconnect between what Adam said he was qualified to do and whether or not he had fully complied with the legislation that would permit him to work in that capacity. Roofmart seems to have hired him without requiring him to produce an Alberta license, although his certificate from Newfoundland, which they did have, and experience on his resume were consistent with him having a journeyman's ticket. While this disconnect is unfortunate, it is apparent that it did not factor into the decisions that led to Adam's death, as following the most basic of classroom training, which Adam certainly had, and the Occupational Health and Safety Code then in place would each have prevented the incident.

The fact of the matter is that Adam Piercey was a very determined young man. He spent two years completing all the classroom requirements necessary to become a crane operator. He sought employment with Roofmart in previous years and was turned down. There is no doubt in my mind that Mr. Graham was probably very discouraging in rejecting Adam's employment application. However, Adam was undeterred, and instead sought work in the demanding oil patch, where he pursued his career for at least 3 years in what surely were difficult circumstances. In spite of the fact that he had been turned down by Roofmart before, he reapplied for employment with them and was accepted. This allowed him to work in the city where his family was living and provided him with good and steady employment, fair compensation and a more reasonable lifestyle. He was a conscientious and motivated worker. His effort to repair the crane, whose malfunction was interfering with his work on May 21, was simply another indication of his determination and willingness to take responsibility for his own work. As he said to Ms. Greer "it was his crane and he would take care of it." This was a clear expression of Adam's nature and desire to accomplish any goal he had – even one as simple as making the deliveries that were scheduled that day. Unfortunately, in so doing, he disregarded a simple but fundamental part of his classroom training, and followed the practice he witnessed many times on the oil rigs without any adverse consequence, only on this occasion where the Occupational Health and Safety Code providing for other physical safeguards at the boom was also not followed, the result was tragedy for all concerned.

Consequences of Adam's Death at the Workplace

Following Adam's death, Roofmart cooperated with the Occupational Health and Safety and police investigations. In addition to the legal consequences outlined hereafter, it was very apparent that Adam's death had a profound impact upon Roofmart's corporate culture. A complete overhaul of their safety policies was instituted. While the former workplace safety policies were not legally deficient, it seemed that they were perhaps not top of mind in the corporate culture, which would not be different than most areas of society. Mr. Robert Foley testified that Roofmart "ramped up" its safety program and upon review of the large amount of documentation provided and assessment of his evidence, I would agree that is a fair characterization. These improvements included:

- New markings and stickers were designed for all equipment,
- Additions and enhancements to general safety rules and guidelines
- Workers' responsibilities were re-drafted following suggestions from Occupational Health and Safety
- Hazards were updated and enhanced
- Cranes and other lifting devices were clearly marked as potential hazards with a warning "Do not attempt to repair on your own"
- Televisions in branch stores were installed to broadcast safety videos providing a consistent message of "Safety First" throughout all of Roofmart stores
- Written policies that prohibited repair to equipment without proper authorization were reintroduced and required to be understood and signed by all employees
- Store Standards were redesigned so that they could be updated quickly and with minimal effort,

- A 3000 square foot facility was built in Calgary for the practical training of employees including on sloped-roof mockups, and
- The Pick Ticket and Fall Protection Plans were updated

Last, but certainly not least, a memorial to Adam Piercey was installed at the store in Gregoire and is obviously cared for diligently. Mr. Foley testified "We never want this to happen again to anyone." I accept that sentiment is sincere and that Roofmart has undertaken to create a Workplace Safety Program that does as much as its management and employees could imagine that would avoid such a terrible tragedy in the future.

Legal Consequences of Adam's Death

Roofmart pleaded guilty to a charge that it contravened Part 19, s. 261 of the Alberta Occupational Health and Safety Code as it failed to "ensure that if elevated parts of powered mobile equipment are being maintained or repaired by workers, the parts and the powered mobile equipment are securely blocked in place and cannot move accidentally."

My brother Judge Jacques imposed a creative sentence upon Roofmart at the sentencing hearing following the guilty plea. In addition to a fine of $11,500, Roofmart was ordered to pay the important and meaningful sum of $338,500 to the Saint John Ambulance for the Adam Piercey Memorial Training Fund Project. Roofmart fully complied with the sentencing orders imposed upon it and paid the full sums promptly. A letter from the Saint John Ambulance was provided to the court as an exhibit. It was reported that the fund established in Adam's name led to the training of 148 high school students in Fort McMurray over approximately 18 months with a projection that this project would be funded to continue for a further two years. The project in Adam's memory was also tasked with creating permanent classroom space to allow for further safety training in our community. This space is to contain a special memorial plaque dedicated to Adam's memory.

The sentence imposed for the regulatory offence that that contributed to the result of Adam's death has therefore had a real and significant positive impact on the community. The lives of hundreds of young people will be impacted into their adulthood. This is training that these teenagers would not have otherwise received in the community. It is not an overstatement to say that the skills they have learned, in Adam's memory, may result in their ability to deal with serious injury or indeed save lives themselves in the future. In that very real sense Adam's untimely and unfortunate death will have had a far-reaching impact.

Personal and Community Consequences

The evidence of Adam's fellow employees and supervisors made it clear that he was a person who was respected and loved by everyone with whom he worked. He went out of his way to be kind to less experienced co-workers and demonstrated a level of motivation and dedication that would be admirable in any employee. He was a determined personality who was not going to let anything stand in the way of his goals and then did the best job he could at any given task. His work exemplified the saying "a job worth doing is worth doing well." Adam's tragic death obviously greatly affected the employees of Roofmart who were working at the time it occurred and also personally affected the persons in the management structure of the company. Further it is clear that he continues to be missed by those who knew him. It almost goes without saying that the circumstances of his death also greatly affected the first responders tasked to deal with it and they have also struggled to come to terms with it. A memorial at the local Roofmart location was

established and is tended in Adam's memory. The personnel at Roofmart and many in our community, including myself and my family, are able to note this sincere gesture of sympathy and loss.

Adam's mother and father, Gail and Ed, were active and interested participants at the Inquiry. They sat patiently through the most difficult of evidence that any parent can imagine hearing, and did so with a quiet grace that was humbling to watch. At the end of the inquiry I asked Gail Piercey if there was anything else she wanted me to know about her son, who was the eldest of her two children by 7 years. I was privileged to hear her loving description of him and feel that I have a sense of the type of person that he was even though she said "there are not enough hours to describe him." She advised that he was "everyone's friend whether they were 4 or 94, or rich or homeless." She described the bewilderment of his many friends who came to visit him in the hospital before his death, and who all said that they had done the same thing Adam had on the cranes on the rigs "hundreds of times" without the tragic result that occurred in this case. To be able to parent a child to the point where he could be as kind as Adam was, and as determined and independent, is a truly wonderful accomplishment. It is cruel indeed that Adam's family will not be able to witness and participate the other lovely things that were surely ahead of him.

As a parent it is unimaginable how one comes to terms with the feelings of grief and loss that Adam's family have had to cope with. However, it is important that they know that it is clear that the tragic circumstances of Adam's death have resulted in many constructive and helpful changes at his workplace, and have had consequences in the community at large that will be far-reaching over many years. In addition, it is clear that he, and the way he lived his life, will not be forgotten by anyone who had the opportunity to know him. His loss will be deeply felt by many, and is profound for the community at large.

Recommendations for the prevention of similar deaths:

Roofmart urged me to make recommendations directing that all employers have similar safety protocols to those that they have developed since Adam's death. Adam's mother wished me to recommend that supervisors (even if they were not qualified operators themselves) be better trained in what equipment operators are and are not permitted to do in relation to equipment they were responsible for operating. Both of these parties essentially were worried about that same thing – that employers might cut corners when it comes to safety of their workers. However, the inquiry heard no evidence of this. Certainly Roofmart's safety program has become much more robust since the incident but even the content of their former program ought to have prevented this dreadful incident, as would the basic pre-apprentice crane operator's training and adherence to the Occupational Health and Safety Code. Had any of these three items been followed by those involved, Adam's family and his community would not have lost him.

Therefore, while I hope it is clear that I recognize (to the extent that I am able to), the magnitude of Adam Piercey's loss to the community and those who loved him, the Court can make no new recommendations for the prevention of similar deaths.

I would like to take the opportunity, on behalf of the community, to express my thanks to the Piercey family for their cooperation and assistance with the inquiry and deep and sincere sympathy to them and their loss and the loss to the community at large in Adam's death.

DATED August 6, 2015,

at Fort McMurray, Alberta.

Original signed by

Stephanie A. Cleary
A Judge of the Provincial Court of Alberta