Worker fatally injured when run over by rail car

January 10, 2020

INVESTIGATION REPORT F-OHS-193220

Alberta

The contents of this report

This document reports the Alberta Occupational Health and Safety (OHS) investigation of a fatal incident that occurred in January 2020. It begins with a short summary of what happened. The rest of the report covers this same information in greater detail.

Incident summary

An operator was moving rail cars when the operator was run over by a rail car sustaining fatal injuries. Co-workers found the operator beneath the rail car and called 911. The operator was pronounced deceased on site by emergency medical services (EMS).

Background information

Employer

Trendwood Limited (Trendwood) was a family owned and operated business established in 1972.Trendwood had 13 employees at the time of the incident. The company loaded and unloaded wood products on rail cars in their rail yard.

Owner

The Owner of the rail car and rail lines was Canadian Pacific (CP) Rail. There was a contract between Trendwood Limited (Trendwood) and CP Rail.

Managing owners

There were two Managers/Co-owners who were responsible for the day to day operations at the work site.

Operator 1

Operator 1 (the deceased worker) was employed by Trendwood for 26 years at the time of the incident. Their job duties included loading/unloading wood products on rail cars using a forklift.

Operator 2

Operator 2 was employed with Trendwood as an operator for about 10 years. Their job duties included loading/unloading wood products onto rail cars using a forklift. Operator 2 had worked with Operator 1 for about 10 years at Trendwood.

Operator 3

Operator 3 was employed with Trendwood for 29 years. Operator 3's main job duties were unloading loads from trucks using a bigger forklift. Operator 3 had worked with Operator 1 for about 26 years at Trendwood.

Classification: Public

Work site, equipment and materials

Trendwood rail yard

Figure 1. Overview of Trendwood work site:

A. Front office

B. Incident location

Classification: Public

Rail cars and warehouse

Figure 2. Long shot facing southwest.

A. Warehouse

B. Area where the Operator 1 was found and pulled out from beneath the rail car by co-workers

Classification: Public

Figure 3. Long shot facing east of rail car 1 and warehouse.

Figure 4. Work area – rail cars 1 and 2.

A) The brake wheel

B) The work platform Operator 1 would have been standing on prior to the incident

Classification: Public

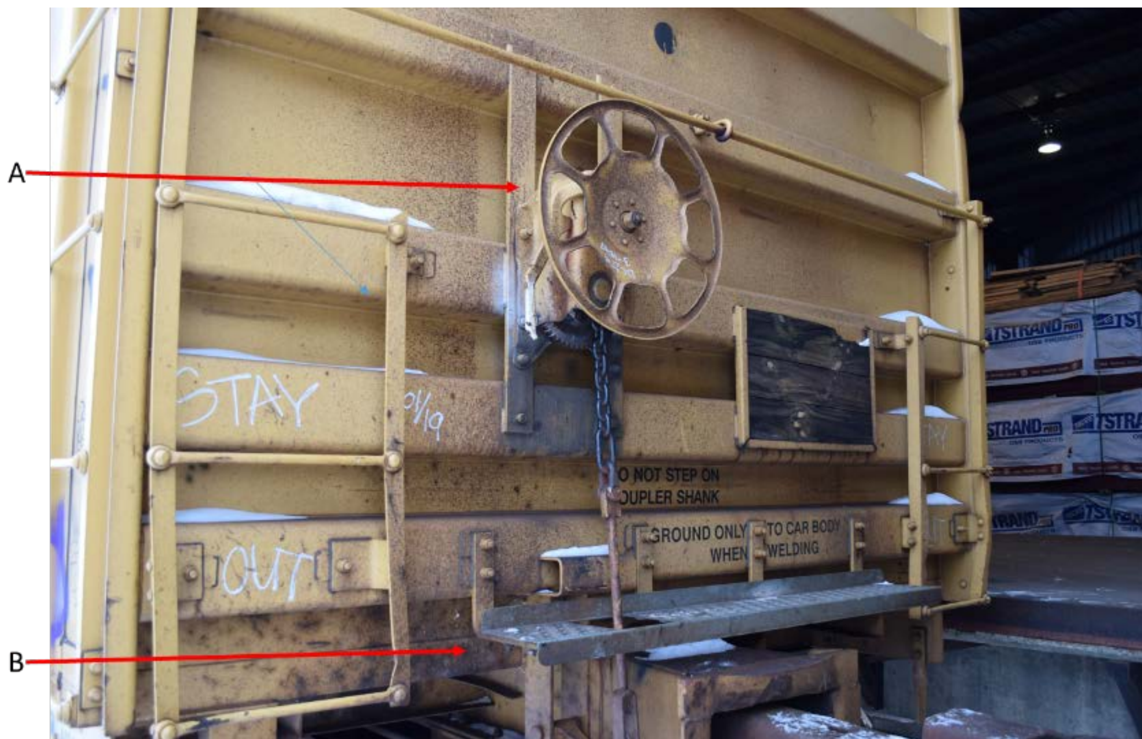

Figure 5. Rail car 2 work area.

A) Brake wheel
B) Platform

Classification: Public

Figure 6. Work area of rail car 2 with scale. Each section of the survey measurement stick indicates 1 metre. The platform measured 1.3 metres from the ground.

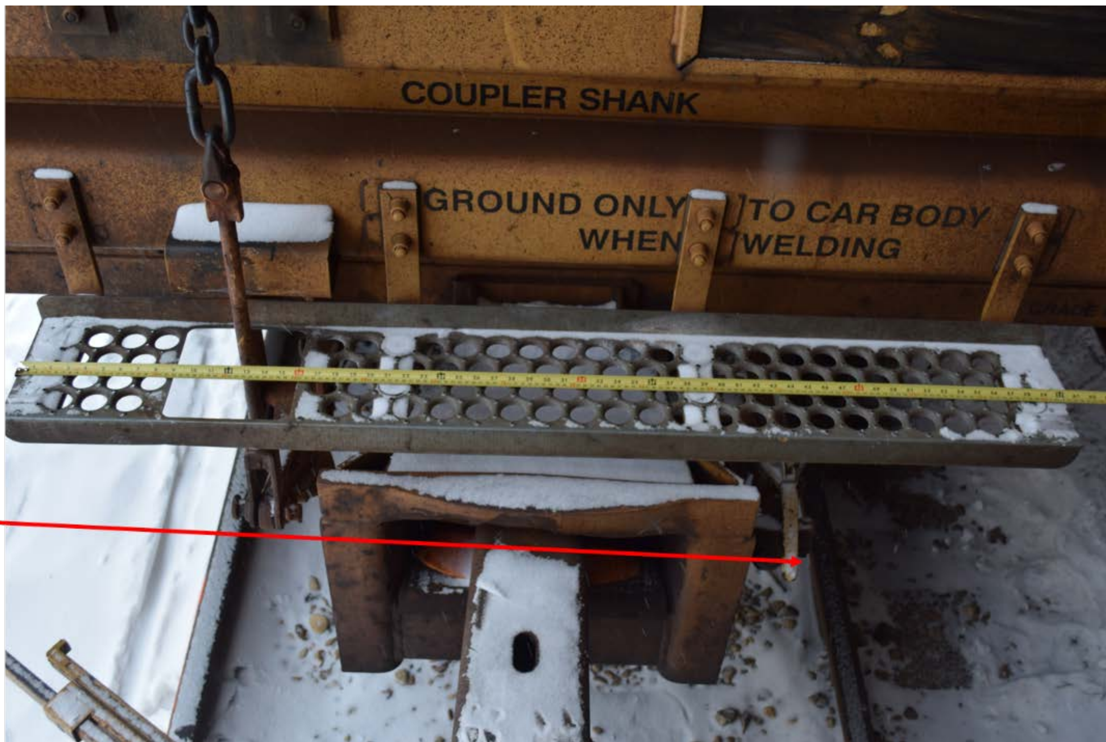

Figure 7. Mid-shot of the 1.63 metre worker platform on rail car 2.

A. Rail the Operator fell on.

Classification: Public

Figure 8. Rail car 2

A. Rail and wheels that ran over Operator 1.

Classification: Public

Figure 9. Area where Operator 1 was found by co-workers below rail car 2.

A. Markings in the snow indicated the worker was dragged out from beneath the rail car in a northward direction.

Sequence of events

On January 10, 2020, at 6:00 a.m., forklift/rail car Operator 1 arrived at Trendwood in Edmonton, Alberta to begin work.

Operator 1 spent the next three hours loading the first rail car by using a forklift to place wood products from the warehouse called “Marc’s Warehouse” in the Trendwood rail yard onto the rail car. Once the first car was loaded, Operator 1 asked Operator 2 to assist moving rail cars 1-3 west so they would line up with the warehouse doors and they could continue loading them.

Operator 1 and Operator 2 moved the rail cars forward and once they were in position both Operator 1 and Operator 2 applied the brakes. Operator 1 asked Operator 2 if the cars were parked in the correct position and Operator 2 said they were.

Shortly thereafter, Operator 1 asked Operator 3 to help move the same rail cars forward. Operator 3 agreed and went to rail car 1 which was located furthest to the west on the rails. Operator 1 went to the middle 2 rail car. Both Operator 1 and Operator 3 climbed onto the platforms and both Operators released their wheel brakes to allow the cars to move west with gravity.

Classification: Public

Since Operator 3 was assisting Operator 1 with the task, Operator 3 waited for Operator 1 to put on the brakes once the rail cars reached the desired position. Operator 3 noticed that the cars had passed the markings on the warehouse, which indicated the stopping location, and were approaching the end of the rail line. Operator 3 applied the wheel brake so that the rail cars did not de-rail and moved down off the platform.

Operator 3 began looking for Operator 1 around the rail line and could not find Operator 1. Operator 3 then went into the main warehouse assuming Operator 1 must have gone there but still did not locate Operator 1.

Operator 3 returned to the rail cars 1- 3 approaching from the north and looked under the cars. Operator 3 found Operator 1 unconscious underneath rail car 2. Operator 1 was found in a supine position with their head pointing north and their torso laying over the south rail.

Operator 3 called for help over the radio and one of the managing owners and Operator 2 came to their aid. Once they arrived, someone asked over the radio for 911 to be called. Another forklift Operator contacted 911.

Operator 2 and the managing owner then moved Operator 1 into the Trendwood office lobby and initiated cardiopulmonary resuscitation while waiting for EMS to arrive. Once EMS arrived, Operator 1 was assessed and declared deceased.

Completion

A review for enforcement action was completed on July 9, 2020, and it was determined that the file would be referred to Alberta Justice for review. The entire file was sent to Alberta Justice on October 16, 2020. Charges were laid on November 23, 2021. On August 26, 2022, Trendwood Limited pled guilty to contravention of Section 139(1)(b) of the Occupational Health and Safety Code for failing to ensure that a worker was protected from falling, if a worker could fall at a temporary or permanent work area, a vertical distance of less than three metres if there was an unusual possibility of injury. At sentencing, Trendwood Limited was fined $150,000, inclusive of the 20 per cent victim fine surcharge, and placed on 18 months of Enhanced Regulatory Supervision.

This investigation was completed on October 18, 2022

Classification: Public

Signatures

ORIGINAL REPORT SIGNED

Lead Investigator

October 18, 2022

Date

ORIGINAL REPORT SIGNED

Manager

October 18, 2022

Date

Classification: Public