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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Court House

in the Hamlet (City, Town or Village) of Sherwood Park (Name of City, Town, Village), in the Province of Alberta,

on the 6th day of November, 2017 (year), (and by adjournment

on the 7th day of November, 2017 (year)),

before D.G. Rae, a Provincial Court Judge,

into the death of Cody Mason Demary (Name in Full) 18 (Age)

of P.O. Box 641 Bon Accord, Alberta (Residence) and the following findings were made:

Date and Time of Death: November 2, 2011 at approximately 7 p.m.

Place: 21423 Township Road 554 Strathcona County, 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 – *Fatality Inquiries Act*, Section 1(d)).

Multiple Blunt Injuries

Manner of Death:

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

Accidental

Circumstances under which Death occurred:

The deceased, 18-year-old Cody Mason Demary (Cody), had worked as a labourer at a warehouse owned by CN Worldwide Distribution Services (Canada) Inc. (the Company) for about two months prior to the accident. The warehouse is a receiving, storage, and distribution centre for steel products.

On the early evening of November 2, 2011, a flat-deck trailer (the trailer), without the tractor unit attached (the truck), located in a crane bay inside the warehouse had just been loaded with bundles of rebar with the use of an overhead crane. Cody was directed by the crane operator to copy information off of tags attached to the bundles of rebar. Another worker (the driver) was directed by the crane operator to back the truck into the crane bay and hook it up to the trailer so that it could be pulled out of the warehouse into the yard. The driver checked the side mirrors, sounded the horn, and backed the truck into the crane bay. Before the truck could attach to the trailer, the driver stopped backing up the truck and walked to the rear of the truck where he set the “fifth-wheel device” so it would hook up to the trailer. He then re-entered the truck, sounded the horn, and using the side mirrors, backed the truck up to and hooked onto the trailer.

While no one witnessed the accident, it is evident from the investigation done by Alberta Occupational Health and Safety that Cody, while copying the information from the bundles of rebar, was standing at the front of the trailer directly behind the rear passenger wheels of the truck as it backed up to the trailer. Tragically, Cody was run over by the rear passenger wheels of the truck as it hooked up to the trailer.

The truck was equipped, for the safety of the occupants, with what is called a “headache rack” which prevents viewing of the back of the truck through the back window of the truck. The truck was also equipped with passenger and driver-side mirrors, back-up and brake lights, an air horn, and a back-up alarm. The Alberta Occupational and Safety investigation found that the passenger-side mirror’s viewing image was limited to the outer area of the truck’s rear wheels and could not see where Cody was standing.

The truck’s back-up alarm was tested shortly after the accident. It worked, but was difficult to hear over the truck’s engine, and the speaker for the alarm located at the back of the truck faced away from the rear path of the truck. A subsequent mechanical inspection of the alarm found the wiring to the speaker was corroded suggesting the alarm may only have worked intermittently which was consistent with the Occupational Health and Safety’s investigation. Further testing of the alarm by an acoustical consultant retained by the company found the back-up alarm and truck horn to be audible over expected background noise. In any event, a louder back-up alarm was installed on the truck. The truck’s back-up and brake lights as well as the air horn were tested after the accident and found to be working.

Operating the truck on a public highway would require the driver to have a Class 1 licence. The driver of the truck involved in the accident did not have a Class 1 licence; he only had a motorcycle licence from another province. The truck was a shunt truck used to shunt trailers from one area of the company’s property to another. As long as the truck did not leave the company’s private property, drivers were not legally required to have the appropriate commercial truck Class 1 driver’s licence. The company appears to have had a written policy in place at the time of the accident which required the driver of the shunt truck before backing into the warehouse and the crane bay to blow the horn twice. Occupational Health and Safety’s investigation found the driver did blow the horn, but it was unclear how many times. A re-enactment of the accident by the company with the driver found the driver sounded the horn twice.

As noted, the driver did not have a Class 1 driver's licence. To obtain a Class 1 licence, training, including safety training for movement of the truck would be required. Other than the policy referenced in the previous paragraph, no evidence was put before the Fatality Inquiry as to what training, if any, the driver received in the safe operation of the truck.

As a result of their investigation, Occupational Health and Safety issued several orders or directives that the company was required to comply with, which they did. Of particular note, the company was required to and did demonstrate that all workers who operate truck/trailer units be fully aware of and trained in the safe operation of such units. Although not required to, if the truck is not operated on a public highway, the company requires all shunt drivers to have a Class 1 licence. The improved company safety and maintenance policies approved by Occupational Health and Safety require inspection of the back-up alarm prior to operation of shunt trucks and the use of a spotter when the driver is not alone.

Recommendations for the prevention of similar deaths:

According to the evidence of Occupational Health and Safety at the Inquiry, charges were laid under the *Occupational Health and Safety Act* which were subsequently withdrawn by Alberta Justice because, in their opinion, the Company was a federally-regulated entity over which Occupational Health and Safety had no jurisdiction. The evidence suggests this jurisdictional issue was raised early on by Occupational Health and Safety and that mistakenly both the Company and the federal occupational health and safety regulator were of the view the Company was subject to provincial regulation. The Fatality Inquiry was told that by the time the Alberta charges were withdrawn, the limitation period on any possible federal health and safety charges had run out.

Where warranted by the facts, prosecution under health and safety regulation legislation, be it federal or provincial, can serve as a deterrent and thereby prevent similar deaths. Accordingly, I recommend that Occupational Health and Safety work with their federal counterparts to establish a protocol to ensure that very early in any investigation, an accurate determination is made as to jurisdiction.

While the back-up alarm on the truck worked when tested shortly after the accident, the evidence suggests that the alarm may only have worked intermittently because of corroded wiring. It appears from the evidence that the truck did not display the annual decal indicating inspection under the *Alberta Vehicle Inspection Regulation, Alberta Regulation 211/2006*. The evidence at the Inquiry suggested the truck may have, from time to time, left the Company's private property and travelled on a public highway to be refuelled. Shortly after the conclusion of the evidentiary portion of the Fatality Inquiry, Inquiry counsel provided me with a written opinion that the truck would have been required to have an annual inspection under the *Alberta Vehicle Inspection Regulation, Alberta Regulation 211/2006* because it was a commercial vehicle operated on a highway. Further to this opinion, counsel for the Company advised me by letter that she reviewed this matter with the Company who informed her that the shunt trucks are fuelled onsite and not used on a highway.

In any event, Inquiry counsel has advised me that Alberta's Commercial Vehicle Inspection Program does not require inspection of back-up alarms. I recommend that *Alberta Vehicle Inspection Regulation, Alberta Regulation 211/2006* be reviewed to give consideration of the inclusion of back-up alarms as part of the required annual inspection.

DATED December 22, 2017,

at Sherwood Park, Alberta.

"D.G. Rae"

D.G. Rae
A Judge of the Provincial Court of Alberta