

Workplace Health and Safety Fatality Report



WORKER FALLS FROM A LADDER

Date of Incident: September 4, 2007

Type of Incident: Fatality, Worker passed away September 8, 2007

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SECTION 1.0 DATE AND TIME OF INCIDENT

1.1 The incident occurred on September 4, 2007 at approximately 2:45 p.m.

SECTION 2.0 NAME AND ADDRESS OF PRINCIPAL PARTIES

2.1 Owner(s)

2.1.1 BlackWatch Energy Services Operating Corp.
1400, 350 – 7 Avenue SW
Calgary, Alberta
T2P 3N9

2.2 Prime Contractor

2.2.1 N/A

2.3 Employer(s)

2.3.1 BlackWatch Energy Services Trust (A Division of BlackWatch Energy Services Operating Corp.)
6109-46 Street
Leduc, Alberta T9E 6T8

2.4 Contractor(s)

2.4.1 N/A

2.5 Supplier(s)

2.5.1 N/A

2.6 Worker(s)

2.6.1 Maintenance Labourer
Edmonton, Alberta

2.7 Others

2.7.1 N/A

SECTION 3.0 DESCRIPTION OF PRINCIPAL PARTIES

- 3.1 BlackWatch Energy Services Operating Corp. is an oil and gas services company that provides a wide range of services to its customers operating in the Western Canadian Sedimentary Basin. BlackWatch Energy Services Operating Corp. offers drilling, electric wireline services, rig transportation and equipment hauling, coil tubing well services, oilfield equipment leasing and rental services and production services.
- 3.2 BlackWatch Energy Services Trust is a Division of BlackWatch Energy Services Operating Corp.

SECTION 4.0 LOCATION OF INCIDENT

- 4.1 BlackWatch Energy Services Trust
6109-46 Street,
Leduc, AB
T9E 6T8

SECTION 5.0 EQUIPMENT, MATERIAL AND OBSERVATIONS

5.1 Step Ladder

- 5.1.1 2.13 m tall aluminum stepladder. No identifying marks.
(Attachment “A”, Photograph 1)

5.2 Light Box

- 5.2.1 Intrinsically safe light box. It weighed approximately 11–14 kg and measured 127 cm in length, 17 cm wide and 16 cm deep.
(Attachment “A”, Photograph 1, 3)

5.3 Propane Torch

- 5.3.1 Bernzomatic camping propane cylinder Model TX 916 with a torch attachment engaged onto the threads.
(Attachment “A”, Photograph 5, 6)

5.4 Observations

- 5.4.1 There was no eyewitness for this incident. The area was not monitored for security purposes. There was no evidence of the worker working higher than the top two rungs of the stepladder.
- 5.4.2 The ladder was noted having a minor damage to the hinge of the supporting leg. Although BlackWatch Energy Services Trust did not ensure a dual

purpose stepladder/extension ladder was free of obvious defects; the extension ladder configuration used at the time of the incident was not affected by the minor defect in the ladder and did not contribute to the incident.

- 5.4.3 An examination of the light box had determined it was free from any electrical energy at the time of the incident.

SECTION 6.0 NARRATIVE DESCRIPTION OF THE INCIDENT

- 6.1 On September 4, 2007 at approximately 8:00 a.m. Maintenance Labourer arrived for work where he was employed with BlackWatch Energy Service Trust.
- 6.2 At approximately 8:45 a.m. the Maintenance Labourer and the Shop Assistant were preparing to repair electrical wiring on a forklift back up-alarm. Both workers were witnessed repairing the forklift by the Health Safety and Environment (HSE) coordinator as he conducted a site inspection. The two workers were seen at 12:00 p.m. by the HSE coordinator as he left for lunch offsite.
- 6.3 At 1:00 p.m. both workers were seen finishing their lunch by HSE coordinator he returned from lunch. At some point the Maintenance Labourer and the Shop Assistant had completed repairs on the forklift and then Shop Assistant, had proceeded to yard across the street from 6109-46 St, Leduc, AB.
- 6.4 At approximately 2:30 p.m. Maintenance Labourer had made his way to the front office to talk with the Receptionist ; to discuss the whereabouts of a fuel card and returned to the shop after a brief discussion.
- 6.5 At approximately 2:45 p.m. the HSE coordinator went to follow up on another matter with the Maintenance Labourer and found him lying on the floor in a storage area. He was on his back with blood pooling near his left ear with his head wedged between a wooden storage bin and a barrel.
(Attachment “C”, Photograph 1, 2)
- 6.6 The Maintenance Labourer was found with his eyes and mouth open. His left foot was resting on the first step of the stepladder and his right foot resting below the bottom rung and a light box resting on top of his legs and chest.
(Attachment “A”, Photograph 1, 3, 4)

- 6.7 The barrel was moved away from the Maintenance Labourer and the HSE Coordinator shook his shoulders with no response. HSE Coordinator stated at the time that the Maintenance Labourer had a strong pulse and his skin was warm to the touch; however he could not detect any breathing.
- 6.8 The HSE Coordinator shouted for help two to three minutes and did not receive a response. He ran to the front office and instructed the receptionist to call 911 and informed her that the Maintenance Labourer had taken a fall. The HSE Coordinator yelled to the Health Safety and Environment (HSE) Manager for assistance.
- 6.9 The HSE Coordinator and the HSE Manager continued to provide care to the Maintenance Labourer as he lay on the floor. Maintenance Labourer was not breathing and HSE Manager ran to obtain a mouth barrier to start CPR. The HSE Coordinator and the HSE Manager began a two person Cardiopulmonary Resuscitation (CPR) with the HSE Coordinator providing chest compression and HSE Manager providing breaths of air.
- 6.10 Paramedics arrived at the location at approximately 2:55 p.m. taking control of the scene and began an IV and electronic monitoring.
- 6.11 The Maintenance Labourer was transported to a hospital in Edmonton.

SECTION 7.0 ANALYSIS

7.1 Direct Cause

- 7.1.1 The direct cause of the Maintenance Labourer's injuries was his fall to the ground and striking his head on the concrete floor.

7.2 Contributing Factors

- 7.2.1 As there were no eyewitnesses, contributing factors as to how and why the incident occurred was not able to be determined by the Investigators.

SECTION 8.0 FOLLOW-UP/ ACTION TAKEN

8.1 Employment, Immigration and Industry; Workplace Health and Safety Compliance

- 8.1.1 Workplace Health and Safety Compliance ordered BlackWatch Energy Service Trust to conduct an investigation into this incident.
- 8.1.2 Workplace Health and Safety Compliance ordered BlackWatch Energy Service Trust to conduct a hazard assessment for working on a stepladder.

8.2 BlackWatch Energy Service Trust

- 8.2.1 BlackWatch Energy Service Trust submitted an investigation report to Workplace Health and Safety Compliance for review.
- 8.2.2 BlackWatch Energy Service Trust complied with the orders issued to conduct a hazard assessment for working from a ladder.

8.3 Additional Measures

- 8.3.1 No additional measures were implemented at this time.

SECTION 9.0 SIGNATURES

Original Report Signed _____
Lead Investigator Date

Original Report Signed _____
Investigator Date

Original Report Signed _____
Manager Date

Original Report Signed _____
Senior Regional Manager North Date

SECTION 10.0 ATTACHMENTS:

Attachment "A" Photographs

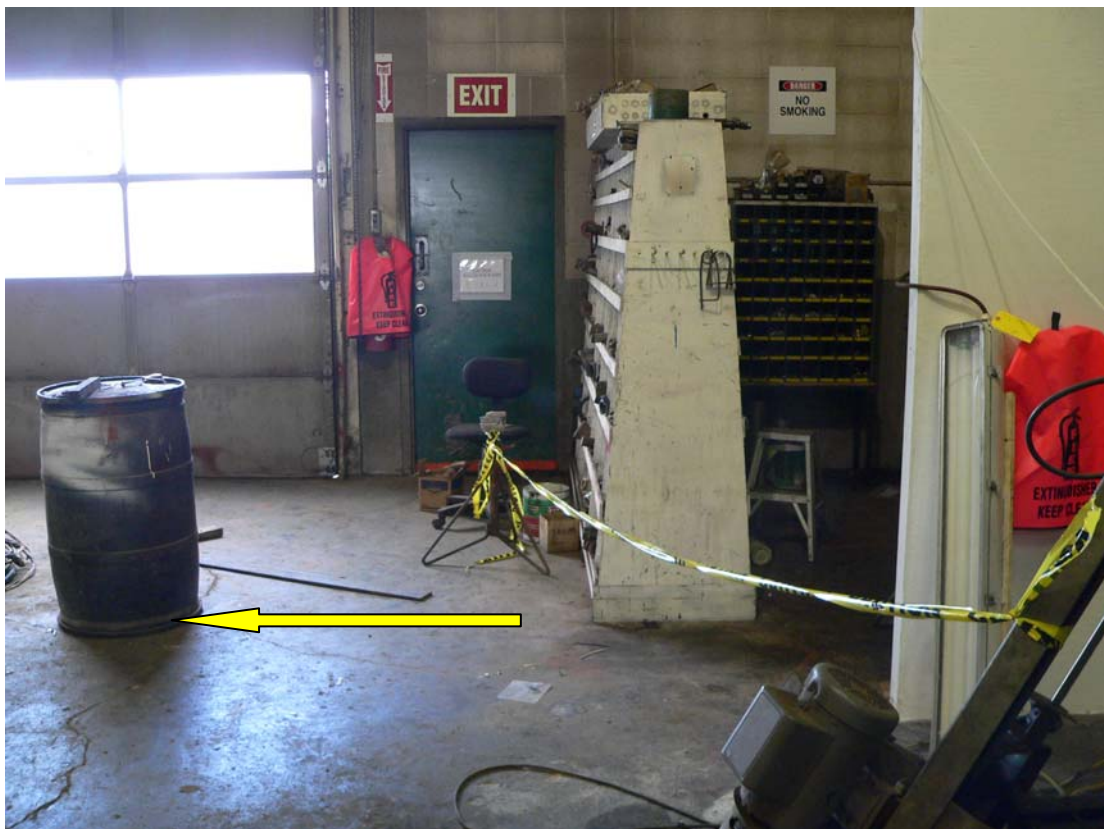


Photograph #1

Inside the East shop facing south, a stepladder located where the light box was installed. Red arrow denotes where the worker's left foot rested. The yellow arrow denotes arrow where the worker's right leg rested. The white arrow denotes the approximate position of the injured worker's head next to the wooden storage bin. The blue arrow shows the front of the light fixture.



Photograph #2 Shows the location of where the injured worker's head was next to the wooden storage bin.



Photograph #3 Shows the barrel that was moved away from the injured worker and the wooden bin to provide space to provide first aid.



Photograph #4

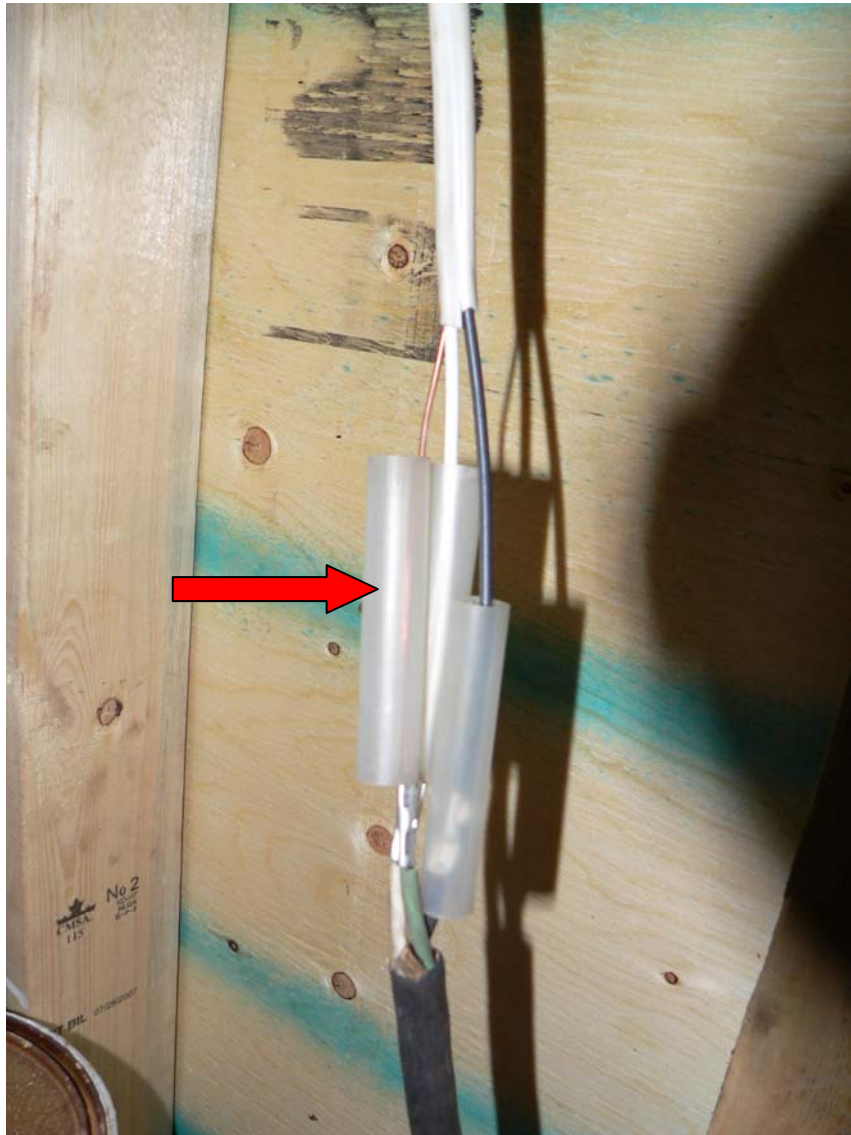
Shows the back of the light fixture that was found on top of the worker. Dimensions were approximately 127 cm in length, 17 cm wide and 16 cm in depth. The light box weighed approximate 11- 14 kg. The light fixture was installed 1 week earlier, mounted to the wall with four (4) 3.8 cm drywall screws at a height of approximately 2.3 m above the floor.



Photograph #5 Shows a 465 g propane cylinder that was found on the floor to the left of the injured worker.



Photograph #6 Illustrates the deformed neck of the 465 g propane cylinder. The yellow arrow shows where the propane cylinder was damaged.



Photograph #7 Shows a connection to the light box with the heat shrink tubing identified by the red arrow. This connection was approximately 1.8 m above the concrete surface.