WORKER DIES OF HEAD INJURY
Type of Incident: Fatality
Date of Incident: May 5, 2012

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SECTION 1.0 DATE AND TIME OF INCIDENT

1.1 May 5, 2012 at approximately 10:45 a.m.

SECTION 2.0 NAME AND ADDRESS OF PRINCIPAL PARTIES

2.1 Owner(s)

2.1.1 Gap Creek Wood Products Inc.
Box 23, Site 18, RR 1
Sundre, Alberta
T0M 1X0

2.2 Prime Contractor

2.2.1 Not applicable.

2.3 Employer(s)

2.3.1 Gap Creek Wood Products Inc.
Box 23, Site 18, RR 1
Sundre, Alberta
T0M 1X0

2.4 Contractor(s)

2.4.1 Not applicable.

2.5 Supplier(s)

2.5.1 Not applicable.

2.6 Worker(s)

2.6.1 The Foreman (**********)

(Names and personal details were removed before distribution of this report.)

2.7 Others

2.7.1 Constable (***** ********)
Sundre RCMP Detachment
215 – 6 Avenue N.E.
Sundre, Alberta
T0M 1X0

SECTION 3.0 DESCRIPTION OF PRINCIPAL PARTIES

3.1 Gap Creek Wood Products Inc. is a privately owned saw mill operation that produces rough-sawn dimensional lumber and fire wood. Gap Creek Wood Products Inc. employed approximate 15 workers at the time of the incident.

3.2 The Foreman (**********) was responsible for the day to day production at the mill as well as ensuring that any required maintenance was scheduled and completed. The Foreman (**********) conducted safety meetings, participated in the hiring of staff, developed safe work procedures and oversaw the training of new staff. The Foreman (**********) had been employed by Gap Creek Wood Products Inc. for approximately 14 years and had previously worked in other saw mills.

SECTION 4.0 LOCATION OF INCIDENT

4.1 The incident occurred in or near the maintenance shop at Gap Creek Wood Products Inc., located on Range Road 60, approximately 3.2 kilometres west of Sundre, Alberta (LSD NE36-32-06W5) (Refer to Attachment A – Map and Attachment B – Photograph 1).

SECTION 5.0 EQUIPMENT, MATERIAL AND OBSERVATIONS

5.1 Equipment and Material

5.1.1 An aluminum ladder measuring 3.6 metres in length. The ladder's manufacturer and age are unknown. The ladder appeared to be the lower portion of an extension ladder as indicated by a pulley affixed to the top rung. The ladder did not have any bottom feet and had minor dents in multiple locations (Refer to Attachment B – Photograph 2).

5.1.2 A wooden work bench measuring approximately 75 centimetres by 122 centimetres and standing approximately 76 centimetres high (Refer to Attachment B – Photograph 3).

5.1.3 A black electrical wire running from the breaker panel in the maintenance shop, along the wall and above the overhead door. This electrical wire had been installed by the Foreman (**********) approximately 6 months prior to the incident (Refer to Attachment B – Photograph 3).

5.2 Observations

5.2.1 Environment Canada reported the weather in Sundre, Alberta on May 5, 2012 was cloudy and rainy with a low temperature of 0.3 degrees Celsius and a high temperature of 9.6 degrees Celsius.

5.2.2 There were drag marks on the concrete floor consistent with the wooden work bench having been moved (Refer to Attachment B – Photograph 3).

5.2.3 The black electrical wire was not attached to the wall. The wire had a bend where it transitioned from a horizontal run to a vertical run (Refer to Attachment B – Photographs 3 and 4).

5.2.4 The bulb in a wall mounted light fixture near the black electrical wire was broken and glass from the broken bulb was lying on the floor below (Refer to Attachment B – Photograph 4).

5.2.5 Marks were observed on the top cross member of the wall consistent with the width of the side rails of a ladder. These marks were approximately 4 metres above the floor (Refer to Attachment B – Photograph 5).

5.2.6 A mark was found on the top of the wooden work bench consistent with the bottom of a ladder rail.

SECTION 6.0 NARRATIVE DESCRIPTION OF THE INCIDENT

6.1 The Foreman (**********) arrived at the work site at approximately 8:00 a.m. on Saturday, May 5, 2012. Worker 1 (**********) and Worker 2 (**********) were already present at the work site performing miscellaneous maintenance duties.

6.2 At approximately 9:10 a.m., Worker 1 (**********) and Worker 2 (**********) told the Foreman (**********) that they were finished for the day as it was too muddy to do any other work. The Foreman (**********) stated that he would also be done soon as he just had one more task to complete inside the maintenance shop. The Foreman (**********) told Worker 1 (**********) that he needed to pick up wire staples at the hardware store.

6.3 The Foreman (**********) left the work site in his own vehicle while Worker 1 (**********) and Worker 2 (**********) left the work site travelling in Worker 1's (**********) vehicle. Worker 1 (**********) and Worker 2 (**********) followed the Foreman (**********) into Sundre until the Foreman (**********) turned into the hardware store parking lot.

6.4 The Foreman (**********) purchased a package of wire staples at the hardware store and returned to the work site.

6.5 Witness 1 (**********) observed the Foreman (**********) returning to the work site at approximately 9:30 a.m.

6.6 Witness 2 (**********) arrived at the work site at approximately 11:15 a.m. and found the Foreman (**********) lying on the concrete floor just inside the open man door of the maintenance shop. The Foreman (**********) was conscious and called Witness 2 (**********) by name to ask for help.

6.7 The Foreman (**********) told Witness 2 (**********) that he had fallen. The Foreman (**********) was bleeding from the mouth and unable to get up on his own. Witness 2 (**********) called 911.

6.8 Emergency Medical Services arrived shortly thereafter. The Foreman (**********) was transported to the Sundre Hospital. The Foreman (**********) was subsequently transferred to the Foothills Medical Center in Calgary where he died due to head injuries at 8:25 p.m.

SECTION 7.0 ANALYSIS

7.1 Direct Cause

7.1.1 The Foreman (**********) received fatal head injures at the work site; however, the exact mechanism of injury is not known.

7.2 Contributing Factors

7.2.1 The exact mechanism of injury is unknown and there were no witnesses to the incident so contributing factors cannot be determined.

SECTION 8.0 FOLLOW-UP/ ACTION TAKEN

8.1 Human Services, Occupational Health and Safety

8.1.1 On May 6, 2012, Occupational Health and Safety received an incident notification, responded to the scene and commenced an incident investigation.

8.1.2 On May 6, 2012, Occupational Health and Safety issued the following orders to Gap Creek Wood Products Inc.:

- Stop Work Order on relocating the electrical wire until the employer could confirm that the work would be done in compliance with the Occupational Health and Safety legislation.
- Stop Use Order for the ladder.
- Order to conduct an investigation of the incident.
- Order to demonstrate that requirements of Section 18 of the *Occupational Health and Safety Act* related to reportable incidents were understood.

8.1.3 On May 6, 2012, Occupational Health and Safety also issued a Notice to Produce to Gap Creek Wood Products Inc. for the following documents:

- Corporate reporting structure for the work site.
- Training records for the Foreman (**********).
- Copy of Safety Management System/Program.
- Copies of site safety meetings.
- Copy of most recent pay stub for the Foreman (**********).
- Copies of any contracts, applications or agreements between Gap Creek Wood Products Inc. and the Foreman (**********).
- Manufacturer's specifications for the ladder involved in the incident.
- Any maintenance or inspection records for the ladder involved in the incident.
- Any procedures, guidelines or training material regarding maintenance work done by workers outside the course of normal job duties.
- Copy of incident investigation with corrective measures.

8.2 Industry

8.2.1 Gap Creek Wood Products Inc. hired a contractor to complete the task of securing the electrical wire.

8.2.2 Gap Creek Wood Products Inc. removed the ladder from the work site and disposed of it.

8.2.3 Gap Creek Wood Products Inc. completed an investigation of the incident and implemented appropriate corrective actions.

8.2.4 Gap Creek Wood Products Inc. complied with the request from Occupational Health and Safety to provide miscellaneous documentation. Where the requested documents were not available, Gap Greek Wood Products Inc. provided a written response.

8.3 Additional Measures

8.3.1 Not applicable.

SECTION 9.0 SIGNATURES

Original Signed _____
(**********), Lead Investigator Date

Original Signed _____
(**********), Reviewer Date

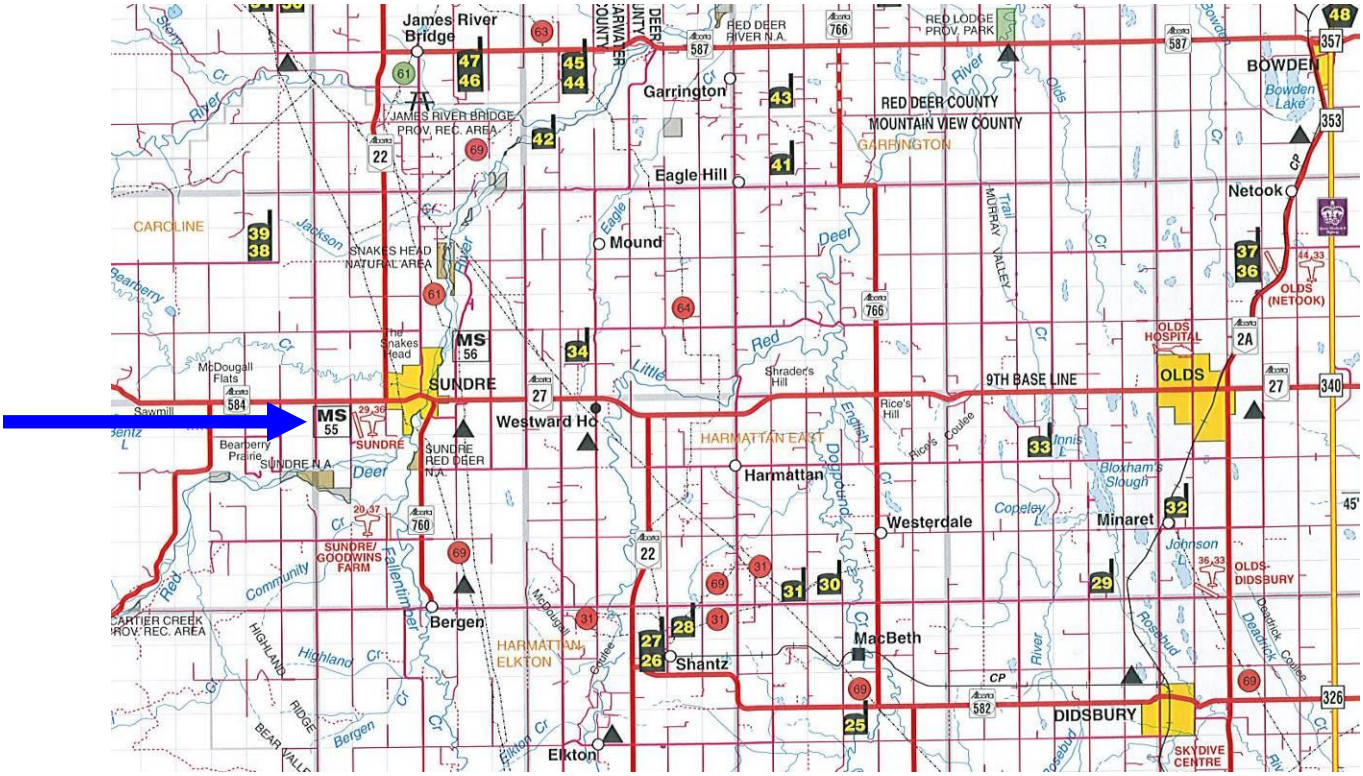
Original Signed _____
(**********), Director South Region Date

SECTION 10.0 ATTACHMENTS:

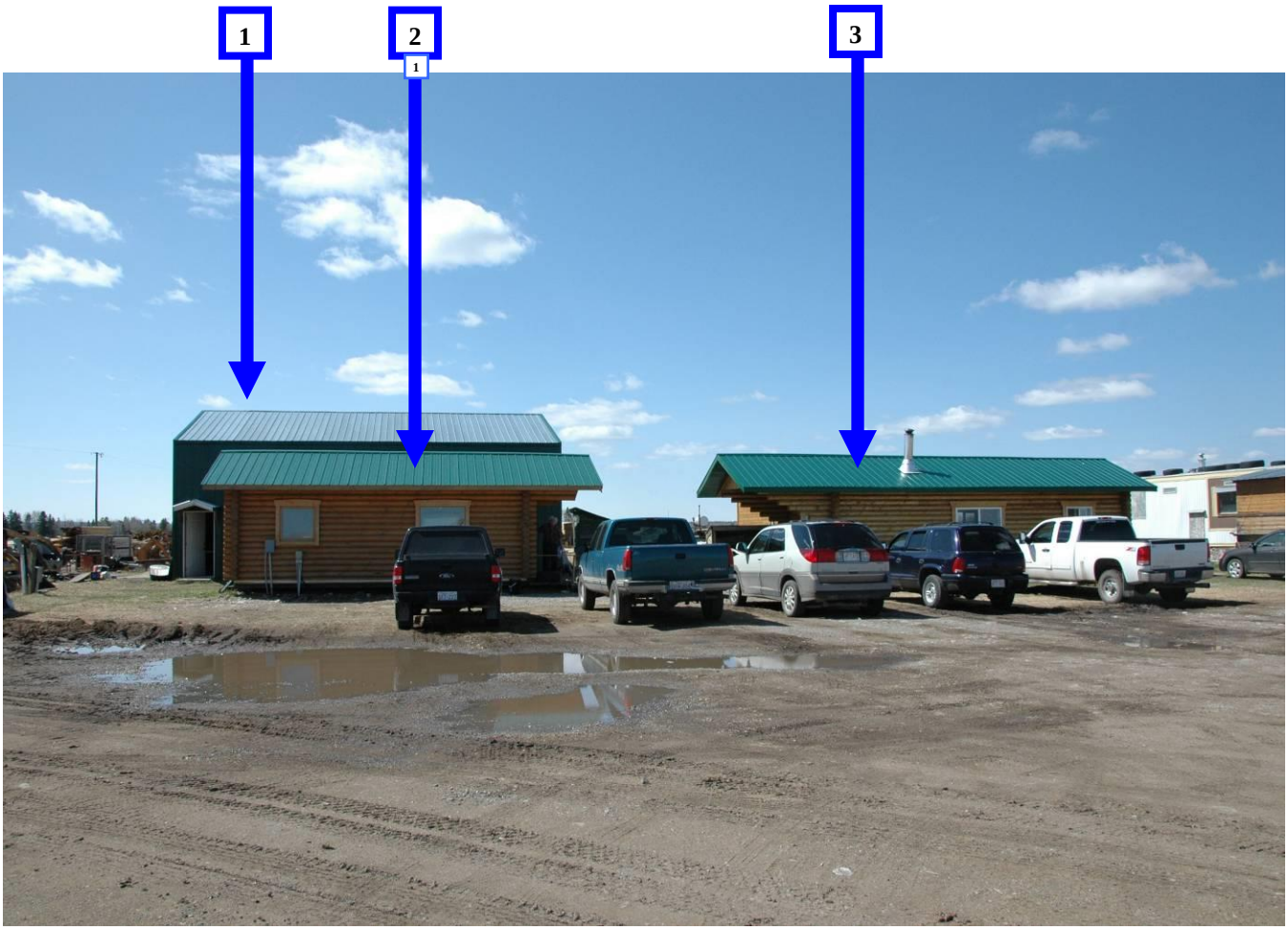
Attachment A – Map
Attachment B – Photographs

GAP CREEK WOOD PRODUCTS INC.

File: F-353989
ATTACHMENT A
Map

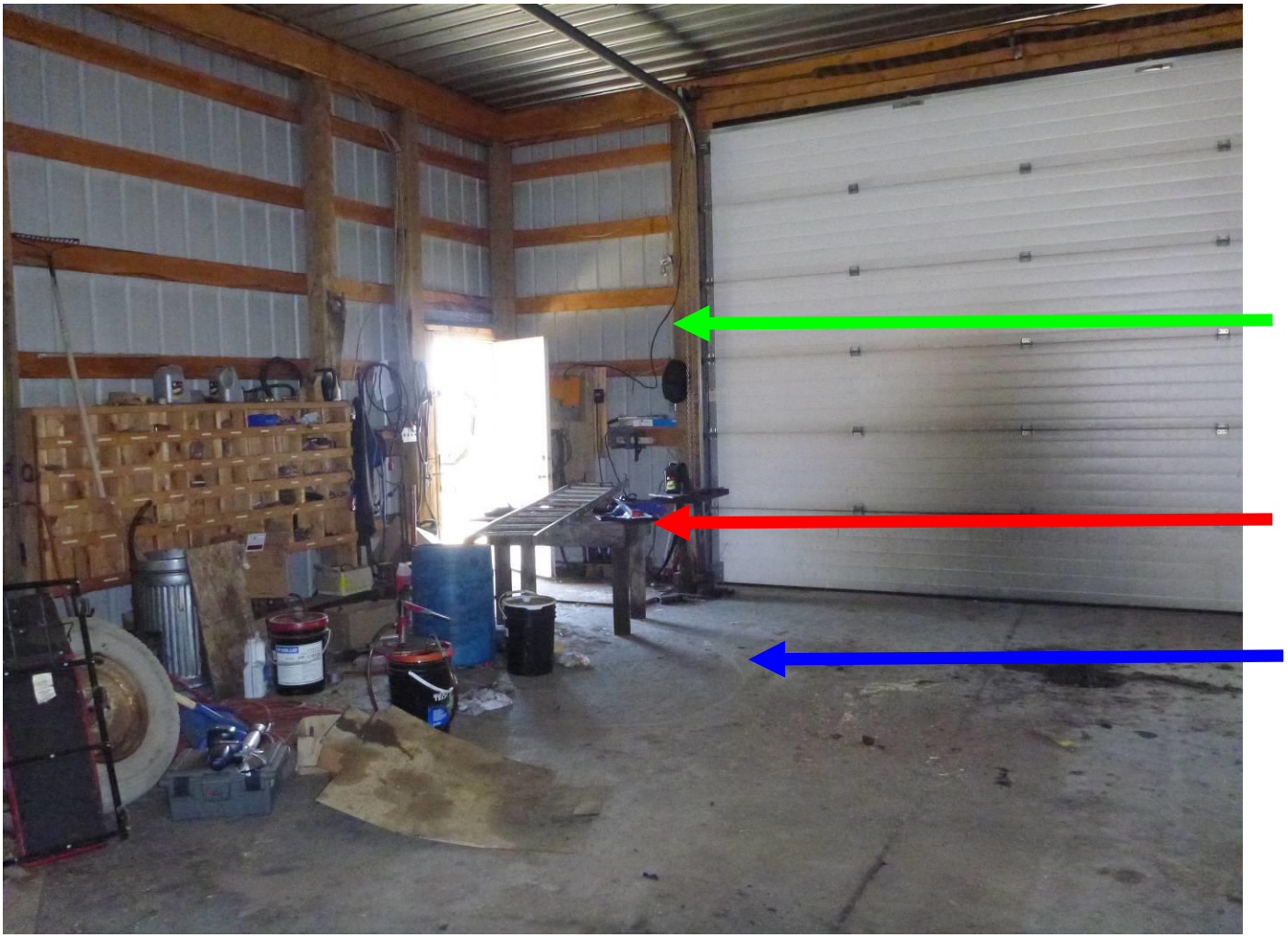


Blue arrow points to the location of Gap Creek Wood Product Inc. located approximately 3.2 kilometres west of Sundre, Alberta on Range Road 60 (LSD NE36-32-06W5).



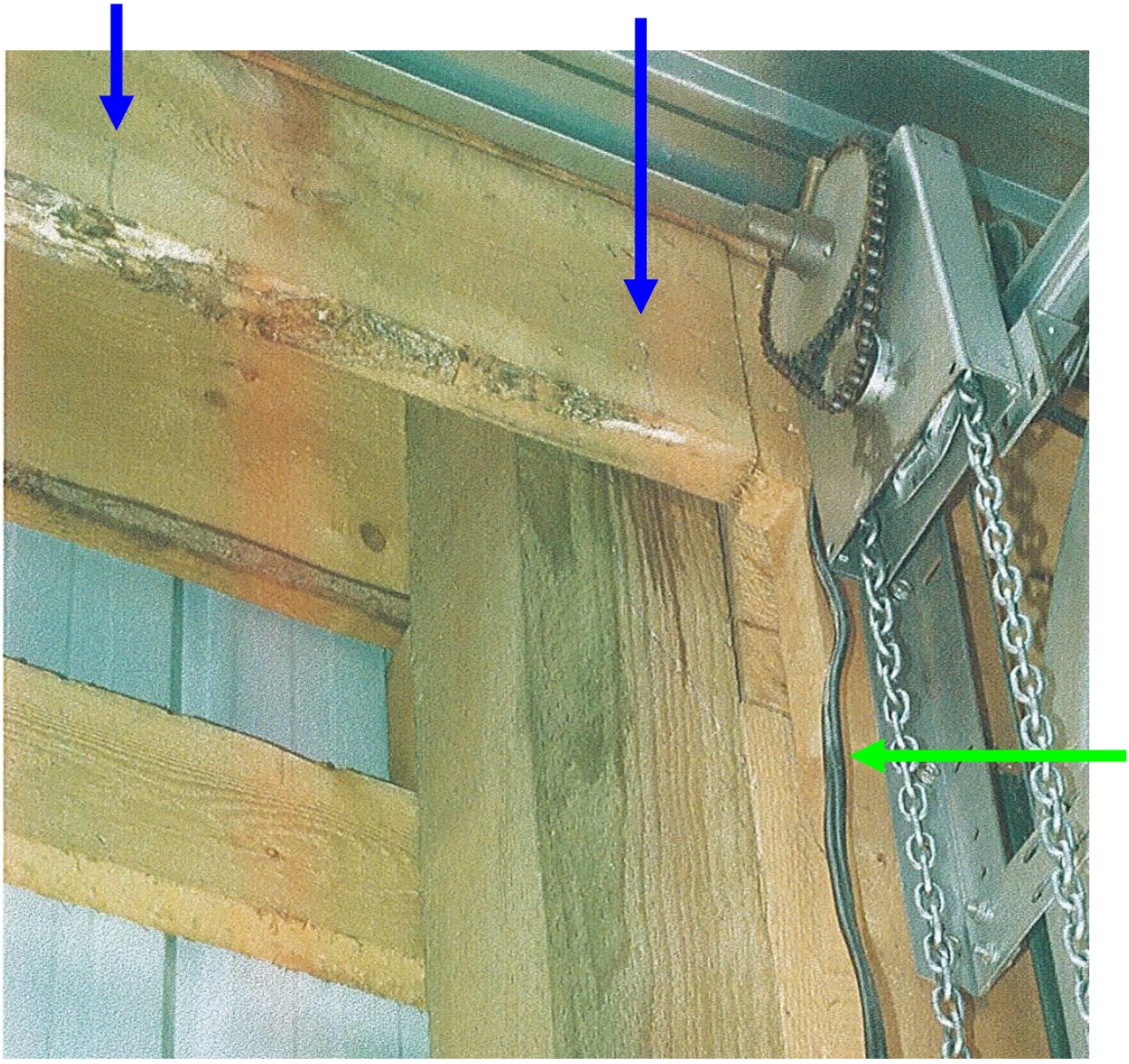
Photograph 1 – Arrow #1 points to the Maintenance Shop. Arrow #2 points to the Office Building. Arrow #3 points to the Lunch Room.

Photograph 2 – Shows the ladder after it had been moved outside the shop by the employer. The blue arrow points to the pulley on the top rung.



Photograph 3 – Re-creation of the scene by the employer (**********) shows the approximate location where he found the ladder lying on top of a wooden work bench.
The blue arrow points to drag marks on the floor.
The red arrow points to the wooden work bench.
The green arrow points to the electrical wire.

Photograph 4 – Re-creation of the scene by the employer (**********) shows the approximate location of the ladder lying on top of a wooden work bench, in relation to the wire the Foreman (**********) was planning to secure. The green arrow points to the bend in the electrical wire. The blue arrow points to the light fixture with a broken bulb.



Photograph 5 – Shows the electrical wire running up and over the overhead door. The blue arrows point to the marks on the upper cross member. The green arrow points to the electrical wire.