Occupational Health and Safety

Fatality Report

Worker Tripped Over Milk Crates

Date of Incident: January 10, 2007
Type of Incident: Fatal

Alberta

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Section 1.0 DATE AND TIME OF INCIDENT

1.1 January 10, 2007 at approximately 4:10 p.m.

Section 2.0 NAME & ADDRESS OF PRINCIPAL STAKEHOLDER(S)

2.1 **Owner**

2.1.1 North-Ed (1994) Ltd.
1500 – 10180 – 101 Street
Edmonton, Alberta

2.2 **Prime Contractor**

2.2.1 Not applicable

2.3 **Employer**

2.3.1 North-Ed (1994) Ltd.

Section 3.0 DESCRIPTION OF PRINCIPAL STAKEHOLDER(S)

3.1 **Owner/Employer**

3.1.1 North- Ed (1994) Ltd. is a small group of companies that currently own and operate several Tim Hortons restaurants in Edmonton and area.

Section 4.0 LOCATION OF INCIDENT

4.1 The restaurant where this incident occurred is located at 420 Manning Crossing in Edmonton, Alberta.

4.2 The incident occurred in the kitchen area of the restaurant in the entrance to the main cooler which leads into the kitchen of the restaurant.

Section 5.0 EQUIPMENT AND MATERIAL INVOLVED

5.1 Milk/cream Crates

5.1.1 The plastic milk crate(s) that the worker tripped over were 266 mm high by 330 mm by 330 mm. The crates hold a 10 litre bag of cream or several cartons of milk. On the day of the incident the crates contained a 10 litre bag of cream. The bag of cream is

eventually taken and placed into a refrigerated holding device where it gets dispensed into coffee as per demand.

5.2 Metal Trays

5.2.1 The see-through wire mesh trays the Worker was carrying at the time of the incident measured approximately 388 mm by 255 mm with a depth of approximately 38 mm, (Attachment "A", Photograph 5).

5.3 Timbits

5.3.1 Timbits are a small, round (with a doughnut like texture) edible product, (Attachment "A", Photograph 5). The Timbits the Worker was carrying at the time of the incident were frozen and weighed approximately 4 kg.

Section 6.0 NARRATIVE DESCRIPTION OF INCIDENT

6.1 On January 10, 2007 at 2:52 p.m., a worker arrived at this work site to begin her duties as a Baker, working the evening shift in the kitchen area of the restaurant. At approximately 4:10 p.m. the Worker entered the main cooler area and proceeded to open a door inside the cooler that led into a walk-in freezer, (Attachment "A", Photographs 2, 3 and 4).

6.2 The Worker walked into the freezer and proceeded to fill three, see-through wire mesh trays with frozen Timbits. The Worker then placed the loaded trays on top of one another and proceeded to leave the freezer. The Worker returned to the main cooler and was proceeding out of the cooler into the kitchen when she tripped over a milk crate that contained a 10 litre bag of cream.

6.3 The Worker landed on the floor outside the cooler near a wooden baker's table in the kitchen area, sustaining a fractured hip/femur, (Attachment "A", Photograph # 2). Co-workers came to the injured Worker's assistance. The injured Worker was helped to a nearby chair and table where she sat and waited for a relative to attend the restaurant and transport her to hospital. No first aid was performed on the injured Worker at the site and Emergency Medical Services was not contacted.

Section 7.0 ANALYSIS

7.1 The injured Worker was admitted to hospital on January 10, 2007 and remained in hospital until she passed away on February 18, 2007. According to the Medical Examiner's Office, the injured Worker died as a result of injuries she received when she tripped and fell on January 10, 2007 at the work site.

7.2 This incident was not reported to Workplace Health and Safety until February 26,

2007, eight days after the Worker passed away in hospital. There was no Manager present or supervision in place at the time of the incident. No first aid services were offered to the injured Worker as there were no first aid trained workers in the restaurant at the time of the incident.

7.3 According to co-workers and despite her injuries, the injured Worker did not want an ambulance to be called for her. Instead, the injured Worker contacted her daughter who was not able to attend the restaurant until 1 hour after the incident occurred to take her mother, (the injured worker) to hospital in her automobile.

7.4 The milk crate that the worker tripped over protruded approximately 140 mm into the door way of the main cooler, (Attachment "A", Photograph 6). The Worker had intended to place the trays of frozen Timbits into a nearby baker's oven for cooking.

7.5 The Worker did not receive the training program that is intended to be given to new workers. The training program was not consistently given to all new workers. The volume of business that this restaurant conducts is significantly more that the existing space allows for product storage. This resulted in an excessive volume of products being stored throughout the working area of the restaurant in a manner that presented tripping and product securement hazards to workers. The restaurant was converted from another donut chain and does significantly more business according to the Manager.

Section 8.0 APPLICABLE LEGISLATION

8.1 **Occupational Health and Safety Act, Section 2(1)(a)(i) Obligations of employers, workers, etc.**

8.1. North-Ed (1994) Ltd. did not do what was reasonable and practicable to ensure the Worker's safety by allowing slipping/tripping hazards to remain uncontrolled throughout the work site, before and after the incident occurred. In addition, the Worker received no training in controlling hazards at the work site and no first aid services were in place at the work site at the time of the incident.

8.2 **Occupational Health and Safety Act, Section 18(1) Serious injuries and accidents**

8.2.1 North-Ed (1994) Ltd. did not report the incident to Workplace Health and Safety Compliance when the Worker tripped and fell and sustained serious injuries on January 10, 2007 and was admitted to hospital for more than 2 days.

8.2.2 North-Ed (1994) Ltd. did not report the death of the injured Worker to Workplace Health and Safety Compliance until eight days after she passed away, despite being aware of her death on the day that she died.

8.2.3 North-Ed (1994) Ltd. disturbed the scene of the incident where the worker sustained serious injuries on January 10, 2007 and did not notify Workplace Health and Safety Compliance.

8.3 **Occupational Health and Safety Code, Section 7(1) Hazard assessment**

8.3.1 North-Ed (1994) Ltd. did not conduct any hazard assessments for the work site where the Worker tripped and sustained serious injuries.

8.4 **Occupational Health and Safety Code, Section 178(1) Providing services, supplies, equipment**

8.4.1 North-Ed (1994) Ltd. did not provide any first aid services to the injured Worker at any time after the incident. The injured Worker waited in the restaurant for 1 hour while her daughter came to pick her up to drive her to hospital.

8.5 **Occupational Health and Safety Code, Section 180(1) Emergency transportation**

8.5.1 North-Ed (1994) Ltd. made no attempt to summon an ambulance to the work site to transport the injured Worker to hospital.

8.6 **Occupational Health and Safety Code, Section 181(1) First aid providers**

8.6.1 North-Ed (1994) had no workers trained in first aid on location at the time of the incident.

8.7 **Occupational Health and Safety Code, Section 185 Housekeeping**

8.7.1 North-Ed (1994) Ltd. did not ensure that a walkway in the main cooler was kept clear of milk crates that caused the Worker to trip and become seriously injured.

Section 9.0 FOLLOW-UP / ACTION TAKEN

9.1 **Alberta Employment, Immigration & Industry**

9.1.1 Workplace Health and Safety Compliance issued several orders to North-Ed (1994) Ltd. for the control of tripping hazards, conducting a hazard assessment, implementing first aid services, reporting of serious injuries and deaths, scene disturbance and ensuring arrangements are in place to summon emergency medical assistance.

9.2 **Industry**

9.2.1 North-Ed (1994) Ltd. complied with all of the orders issued to them by Workplace Health and Safety Compliance.

9.3 **Additional Measures**

9.3.1 Not applicable at this time

Section 10.0 SIGNATURES

ORIGINAL REPORT SIGNED
Investigator _____ Date

ORIGINAL REPORT SIGNED
Investigator _____ Date

ORIGINAL REPORT SIGNED
Manager _____ Date

ORIGINAL REPORT SIGNED
Senior Manager, North _____ Date

Section 11.0 ATTACHMENTS

Attachment “A” Photographs

Photograph #1	Identifies the restaurant located at 420 Manning Crossing in the City of Edmonton where the Worker sustained serious injuries on January 10, 2007 and passed away in hospital on February 18, 2007.

Photograph #2	Identifies the kitchen area of the restaurant. The door to the main cooler is visible to the right of the arrow which indicates the approximate area where the Worker landed after she tripped and fell upon exiting the cooler.

Photograph #3	Shows the inside of the main cooler showing several crates that are used to hold 10 litre bags of cream or several cartons of milk. The door to the walk-in freezer is identified by the arrow.

Photograph #4	Shows frozen product inside the walk-in freezer. The arrow identifies a box of frozen Timbits and the approximate location where the Worker loaded the three trays with the frozen Timbits.

Photograph #5	Identifies a tray of Timbits being held by the Store Manager. This was a re-enactment of similar circumstances that caused the Worker to trip and fall over the milk cartons that contained 10 litre bags of cream visible in the bottom of the photograph.

Photograph #6	Identifies a similar arrangement (to the day of the incident) of milk cartons containing 10 litre bags of cream as reconstructed by the Store Manager. The arrow identifies an edge of the main cooler door frame (see photograph # 2) with the milk/creamcartons protruding into the cooler exit.