Ministry of Justice

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.:2013:5008:0011

HASLAM	BRADLEY MICHAEL THOMAS
SURNAME	GIVEN NAMES

An Inquest was held at Supreme Court, in the municipality of Vernon

in the Province of British Columbia, on the following dates October 20 – 24, 2014

before: T.E. Chico Newell, Presiding Coroner.

into the death of HASLAM, Bradley Michael Thomas 18 ☒ Male ☐ Female
(Last Name) (First Name) (Middle Name) (Age)

The following findings were made:

Date and Time of Death: June 15, 2013 at or around 2:00am

Place of Death: Tolko, Lavington Planer Mill Lavington, BC
(Location) (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Blunt Trauma

Due to or as a consequence of

Antecedent Cause if any: b)

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☒ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 24th day of October AD, 2014

T.E. Chico Newell
Presiding Coroner's Printed Name

Presiding Coroner's Signature

HASLAM	BRADLEY MICHAEL THOMAS
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	T.E. Chico Newell
Inquest Counsel:	John M. Orr, QC
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Tolko Industries Ltd./Gavin Marshall United Steel Workers/Ron Corbeil WorkSafeBC/Gerald W. Massing & Mark M. Skorah, QC

The Sheriff took charge of the jury and recorded 12 exhibits. 21 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

The inquest heard that 18 year old Bradley Michael Thomas Haslam enjoyed family outings and was a talented hockey player, achieved good grades in school, and enjoyed many activities including kayaking, mountain biking, paint ball and video games. It was said that Bradley did not go to work tired. He was noted to be a good worker who completed assigned tasks efficiently.

Evidence revealed that Bradley had his training and orientation at Tolko's Lavington Planer Mill on March 13, 2013. Following this, he began working on the sawmill's weekend graveyard clean-up shift on March 16, 2013.

Testimony from Bradley's co-workers revealed that training and orientation for the students who were to be working the weekend graveyard clean-up shift included a review of safe work practices. This comprised the clean-up shift supervisor describing safe work practices for 'Blowdown Clean-up Operator', MCC Lock Out Stations, Crane Platform use during blowdown, Lockout Procedure, Personal Protective Equipment and Cleaning with Compressed Air". Also reviewed was a six page document entitled "Sawmill Cleanup General Hazard Assessment and Training Briefing". Bradley signed a form confirming completion of the review with his supervisor. An employee orientation manual was also provided. A WorkSafeBC video and another video were watched.

The inquest heard that Bradley attended the mill on Saturday, June 15, 2013 for his shift that was to start at 12:30am. The production shift ran late that night to accommodate a pending change in wood species that was to take place on Monday. It was reported that he was directed to begin cleaning in the vicinity of Chipper #3 and to stay away from the energized/moving 'High Sky' conveyor belt. The supervisor left the area to attend to another matter. Bradley was working on his own in the area and had no radio communication. He was to complete a few tasks which, in part, required the use an air hose with a wand to 'blow down' or clean the areas of sawdust/wood debris.

It was heard that on the supervisor's return to the area he noted that the 'High Sky' conveyor belt was not running yet the drive chain was moving. On further inspection, he found Bradley entangled in the return belt at the point of a non-energized idler roller structure. The supervisor immediately shut down the equipment and called for assistance. His effort to remove Bradley was unsuccessful. No signs of life were found and artificial respiration was attempted. 9-1-1 was called.

The supervisor directed a worker to go and get a sawzall type saw. On return it was found that the sawzall had no blade. A chainsaw was then obtained and the belt was cut. Bradley was extricated and assessed as having no signs of life. Cardiopulmonary resuscitation (CPR) was undertaken. The mill's automatic external defibrillator (AED) was obtained, hooked up and did not advise any shock. CPR was continued. A BC Ambulance was dispatched at 0157 hours. Two paramedics attended at 0210 hours and completed an assessment. No vital signs were found.

Members of the Lavington Fire Department arrived and assisted with resuscitation efforts. The RCMP attended and photographs and statements were obtained. Bradley was transported via ambulance to the Emergency Department at Vernon Jubilee Hospital. Just prior to arrival at hospital, shock was indicated on the AED and given. Following an assessment by the emergency physician, death was declared at 0250 hours. The emergency physician was of the opinion that Bradley had, in fact, died of blunt trauma at the mill site. Subsequent toxicology examination revealed no evidence of alcohol or illicit drugs.

Testimony described that Bradley was discovered in a face down position and on his knees with his right shoulder wedged below the conveyor return belt and above idler roller. His right arm had passed through that equipment. The air wand/hose that Bradley had been using was found on the floor directly below him and reported to have been turned off.

It was heard that Bradley had cleaned the area below the 'Board Edger Outfeed Belt' and in a northerly direction to the south margin of the parallel 'Sky High Waste Conveyor'. Evidence indicated that he then passed his air wand under the moving return belt for the 'Sky High Waste Conveyor' and moved south, then up a set of stairs at the south end of the 'Board Edger Outfeed Transfer" deck, across part of the deck in a semi-circular clockwise direction onto the stationary 'Board Edger Good Board Dropout Conveyor' belt. He took a few steps before hopping down to the south into the space that separated that conveyor from the parallel and energized 'Sky High Waste Conveyor' return belt. His cleaning continued at the east end of that space and evidence indicated that he was cleaning in a westerly direction.

Scene examination revealed a bolt sticking up through the floor approximately one half inch. The bolt was 26.5 inches north of the return belt and 44 inches east of the idler roller that Bradley was found at. This bolt was identified as the remnant of a machine mount that was removed likely as a part of a renovation in 1999. There were windrows of sawdust adjacent to this space indicating Bradley's last work may well have been done there.
The bolt was identified as a tripping hazard and in relatively close proximity to the conveyor return belt. No evidence was found that proved the bolt was involved in the incident.

Bradley's supervisor told the inquest that Bradley had worked in the area of the #3 Chipper before several times and had worked there when the conveyors were operational.

Evidence revealed that a guarding audit was undertaken at the mill prior to Bradley's death. Some areas had direct guarding and there were plans to install additional guarding. The Chipper #3 area had incomplete/ineffective perimeter guarding. It was reported that since the time of Bradley's death, extensive guarding has been put in place. The Sky High Waste Conveyor return belt has since been directly guarded and the old bolt that was sticking up through the floor has been removed.

The inquest heard that shortly after Bradley's death, the mill stopped the student weekend graveyard clean-up shift. There was a changeover to using full-time clean-up workers. Each worker is now supplied with a radio for communication and a buddy system has been put in place towards increasing worker safety.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: **WorkSafeBC**

1. To develop an educational tool about the risks associated with worker fatigue.

   Coroner's Comments: The jury heard evidence that the safety meetings are no longer held during the final break of the graveyard shift as some student workers were approaching exhaustion and therefore reducing their attentiveness. It was stated that one young worker fell asleep while driving home.

2. To include worker fatigue as a component of the COR Audit.

   Coroner's Comments: The jury heard evidence that fatigue was a safety risk factor facing the graveyard clean-up shift worker. WorkSafeBC has a Certificate of Recognition ("COR") that promotes workplace safety, in part, by providing employers with financial incentive to take a proactive role in promoting occupational health and safety systems.

3. Review and research with industry new training styles/curriculum for young/new workers.

   Coroner's Comments: The jury heard evidence that revealed the students found the training somewhat abstract and challenging as it was initially based on materials on paper. Subsequent orientation tours were helpful as they included a direct visual observation of various mill features. It was heard that computerized video means of training may well prove more effective.

4. That workplace inspections incorporate all shifts including Day, Afternoon, Graveyard and Weekend shifts.

   Coroner's Comments: The jury heard evidence that WorkSafeBC site inspections of the mill did not include the student's weekend graveyard shift.

To: **BC Ambulance Service**

5. Ensure that counselling be made available in a timely fashion to Ambulance Attendants following calls of traumatic arrest and similar critical incidents.

   Coroner's Comments: The jury heard evidence that paramedics described this particular call as upsetting and no counselling was offered or sought.

To: **Pat Donnelly, Plant Manager**
Lavington Division, Tolko Industries Ltd.

6. To produce an educational tool to share across all Tolko operations and industry that describes the lessons learned and depicts the safety standards accomplished since the death of Bradley Haslam.

   Coroner's Comments: The jury heard evidence that the mill had undertaken a comprehensive safety review, developed additional safety standards and made physical changes to the mill that were believed to be industry leading.

To: **BC Forest Safety Council**
Manufacturing Advisory Group

7. That BC Forest Safety Council and the Manufacturing Advisory Group utilize Tolko Lavington's Planer Mill safety measures as a benchmark.

   No Coroner's Comment.