Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2010-729-0008

An Inquest was held at Williams Lake Court House, in the municipality of Williams Lake

in the Province of British Columbia, on the following dates 13 - 16 February, 2012

before T.E. Chico Newell, Presiding Coroner,

into the death of ENGELBERT Charles Henry 29 ☒ Male ☐ Female
(Last Name, First Name, Middle Name) (Age)

and the following findings were made:

Date and Time of Death: 17th April 2010 @ 19:54 hours

Place of Death: Royal Inland Hospital (Location) Kamloops, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Traumatic brain injuries

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Being struck by a falling tree

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: None

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

The above verdict certified by the Jury on the 16th day of February AD, 2012.

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

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

FILE NO: 2010-729-0008

ENGELBERT	CHARLES HENRY
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: T.E. Chico Newell

Inquest Counsel: John M. Orr

Court Recording Agency: Verbatim Words West Ltd.

Participants: Scott Nielsen on behalf of WorkSafeBC assisted by Audrey Tate.
Andy King and Ron Corbeil on behalf of United Steelworkers.
Stephanie Vellins on behalf of West Fraser Mills Ltd.
Morgan Burris on behalf of BC Forest Safety Council.

The Deputy Sheriff took charge of the Jury and recorded 10 exhibits.
11 witnesses were duly sworn in 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.

This Inquest examined the death of Mr. Charles ("Charlie") Henry Engelbert who was an experienced, professional, previously certified and respected hand tree faller.

On April 16, 2010 at approximately 07:30 hours, Mr. Engelbert and the falling contractor ('the contractor') who hired him began their day's work within a wooded forestry worksite east of Opheim Lake in the vicinity of Likely, BC. The two fallers were a few days into completing 'trap tree' falling; a technique utilized to reduce overall beetle population levels. Over the morning the contractor had been working near the site landing. Mr. Engelbert had moved onto an area approximately 500 metres downslope and was working along a path identified by flagging tape. The two workers had been in regular contact via handheld radio. At approximately 11:00 hours Mr. Engelbert did not respond to the contractor's radio call. An estimated thirty minutes later, the contractor located Mr. Engelbert motionless on the ground with significant head trauma. No signs of life were apparent to the contractor. His chainsaw was found idling. The contractor could not call out via radio from the location. He subsequently made his way approximately 650 metres downslope and out to a nearby roadway and subsequently to a residence. He obtained the use of a vehicle and then drove approximately 2.5 kilometres to another house where he called the forest licensee's office for the help.

ENGELBERT	CHARLES HENRY
SURNAME	GIVEN NAMES

A 9-1-1 call was made from the office at approximately 12:25 hours. Fire/Rescue and Ambulance crews were dispatched. The scene location could not be identified through existing 9-1-1 mapping; therefore, arrangements were made for responders to meet with the contractor at an identified location.

The Fire/Rescue crew were first to meet with the contractor. They obtained verbal direction as to the route and location and set out to find the site in an area largely unknown to them.

The Ambulance crew subsequently met with the contractor and travelled with him to the site landing together. They understood from the contractor that Mr. Engelbert was deceased. All made their way through the challenging terrain to attend to Mr. Engelbert at approximately 13:03 hours. Mr. Engelbert was assessed and found to be alive and unconscious. He was given first aid and ultimately stabilized for ground transfer.

The Fire/Rescue crew attended the location and assisted. Their delay in attending was due to not being able to find the location and having no radio contact with other responders. RCMP attended and assisted with the process of transporting Mr. Engelbert out to a location where he was extracted via helicopter at approximately 16:08 hours. His care was turned over to Cariboo Memorial Hospital at approximately 16:26 hours. He was assessed and diagnosed with traumatic head and left sided chest injuries. His prognosis was poor.

Mr. Engelbert was then transferred to Royal Inland Hospital for assessment and prospective treatment. Clinical assessment revealed that surgical treatment was not an option. The criteria for brain death were established on April 17, 2010 at 12:35 hours. Medical support was subsequently withdrawn and comfort measures were put in place. Mr. Engelbert passed away later that day at 19:54 hours. Subsequent toxicology revealed no alcohol or illicit drugs. The only drug identified was attributed to emergency medical treatment.

The incident in which Mr. Engelbert sustained the injuries was not witnessed. Expert analysis of the scene led to conclusions including Mr. Engelbert having fallen numerous trap trees in the vicinity of where he was found. The final tree felled was situated 4 metres away from a dead fir tree. This 23 metre high dead tree, with a diameter of 40 centimetres, had a 2.73 metre rotten section located 7.62 metres above its base. The 16 metre top section of this tree fell backwards towards the stump of the tree that Mr. Engelbert had just felled. He was 4 metres away from the stump and facing away when struck on the head and left shoulder knocking him to the ground.* The possible scenario emerged that the trees felled in the immediate vicinity created sufficient vibration for the rotten portion of the dead tree to break off.

**(all measures are given as approximations)*

ENGELBERT	CHARLES HENRY
SURNAME	GIVEN NAMES

*Pursuant to Section 38(5) 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: Workers' Compensation Board

1. Occupational Health & Safety Regulations should be amended to require the employer to prepare an evacuation plan prior to commencing work on any hand falling operation. This plan must include but is not limited to:
   - a site map
   - directions to work site from nearest medical treatment centre;
   - latitude/longitude coordinates;
   - communications with confirmed ability to summon off-site assistance from the job sites (e.g. daily radio checks), and
   - marked access/evacuation trails.

   This information must be readily available, before work starts, to the person identified by the employer to monitor safety.

Coroner's Comments: The jury heard evidence that there was an absence of effective planning in the event there was a medical emergency.

2. Occupational Health & Safety Regulations should be amended to require the licensee to assume the responsibilities of the employer for the purposes of health and safety when they contract hand falling work to a contractor utilizing three or fewer fallers.

Coroner's Comments: The jury heard evidence that Occupational Health & Safety Regulation placed the responsibility for the health and safety of the hand faller on the immediate employer. It was heard that in a two faller contract situation, these responsibilities could be exercised more effectively by the licensee.

3. Occupational Health & Safety Regulations should be amended to require mandatory supervisor certification for persons supervising hand falling.

Coroner's Comments: The jury heard evidence that the BC Forest Safety Council's optional 'Faller Supervisor Course' involves training in the effective management of hand falling safety concerns. It was also heard that the successful completion of the Course led to a certification.

4. Occupational Health & Safety Regulations should be amended to require mandatory periodic recertification of fallers that includes documentation of experience and skill level in various timber and terrain types, including trap tree falling. Consideration should be given to a mandatory log book.

   Coroner's Comments: The jury heard evidence of the safety benefits of documented hand faller certification by work type.

5. Review education strategies to clarify worker safety responsibilities of owners and licensees when contracting work to companies employing individual subcontractors.

   Coroner's Comments: The jury heard evidence of the prospective benefit of ongoing efforts at educating owners and licensees as well as contractors and individual subcontractors on the responsibilities of worker safety.

To: BC Forest Safety Council

6. Investigate SPOT satellite transmitters (or similar technology) and incorporate their use into safety plans.

Coroner's Comments: The jury heard evidence of newer technology that would allow for a more effective means of immediate emergency notification including specific location information. It was heard that such an undertaking ought to be integrated with safety planning processes.

7. Review education strategies to clarify worker safety responsibilities for owners and licensees when contracting work to companies employing individual subcontractors.

Coroner's Comments: The jury heard evidence of the prospective benefit of ongoing efforts at educating owners and licensees as well as contractors and indivivual subcontractors on the responsibilities of worker safety.

8. Promote awareness of Falling Supervisor Course and other educational opportunities.

Coroner's Comments: The jury heard evidence of the potential benefit to persuing educating hand fallers and their supervisors in effective safety practices via the completion of established coursework and involvement in other educational opportunities.

To: Minster of Health

9. Explore making BC Ambulance Service Advanced Life Support paramedic services available by local helicopter to residents in the Cariboo and the North, for people living and working in remote locations.

Coroner's Comments: The jury heard evidence that highest level of paramedic training in the Williams Lake area was to a standard for primary care. The Jury also heard that the closest BC Ambulance helicopter medical evacuation service was based out of Kamloops. The catchment area for this service does not include Williams Lake.

To: Emergency Management British Columbia

10. Explore development of a single provincial emergency communication system – for example a common radio frequency that all agencies would have available to use in an emergency.

Coroner's Comments: The jury heard evidence that there was no means for the Fire/Rescue responders and Ambulance Paramedics to communicate. This resulted in the Fire/Rescue responders being effectively without proper directions to the scene and ultimately a significant delay in their attending the scene.