BRITISH COLUMBIA

Ministry of Justice

VERDICT AT CORONERS INQUEST

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

File No.:2012:0607:0044

LITTLE	ALAN HARVEY
SURNAME	GIVEN NAMES

An Inquest was held at Prince George Court House, in the municipality of Prince George

in the Province of British Columbia, on the following dates March 2-25, 2015 & May 11-14, 2015

before: Lisa Lapointe, Presiding Coroner.

into the death of LITTLE (Last Name) Alan (First Name) Harvey (Middle Name) 43 (Age) X Male ☐ Female

The following findings were made:

Date and Time of Death: April 24, 2012 03:51 hours

Place of Death: University Hospital of Northern BC (Location) Prince George, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Respiratory Arrest

Due to or as a consequence of

Antecedent Cause if any: b) Major Burn (94% 3rd degree burns).

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: xAccidental ☐ Homicide ☐ Natural Suicide ☐ Undetermined

The above verdict certified by the Jury on the 14 day of May AD, 2015

Lisa Lapointe
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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: **Forest Safety Council, Manufacturer's Advisory Group and the United Steelworkers' Union**

1. Collaborate to develop a training program with certification to foster active participation in joint Health and Safety Committees.

   (Background to the recommendation: The inquest heard that active joint Occupational Health and Safety Committees are a key factor in supporting worker health and safety but that there are challenges ensuring appropriate representation, attendance and effectiveness.)

To: **United Steelworkers' Union**

2. The Steelworkers' Newsletter should be mailed to the homes of workers in the wood manufacturing industry on an annual basis.

   (Background to the Recommendation: So that the family members are aware of the safety issues at the workplace. This would allow the family members to be a part of the safety process.)

To: **RCMP**

3. Develop policy, guidelines and training for the investigation of criminal negligence in the workplace.

   (Background to the recommendation: The inquest heard that the RCMP investigation into the mill explosion was concluded after 2 ½ days without interviewing any mill managers or reviewing workplace policies or practices and a report was never issued.)

4. Include work-site serious injuries and fatalities as "bench-mark" offences to be reported to the District Senior Investigating Officer.

   (Background to the recommendation: The inquest heard that offences designated as bench-mark offences are investigated with major case management methodology.)

To: **BC Ambulance Service**

5. Conduct a review of the Technical Advisor Program to ensure ambulance response is timely and coordinated with an established Incident Command model.

   (Background to the recommendation: The inquest heard that ambulances did not respond to the Command Post at the Lakeland mill site but parked a significant distance away leaving critically and mortally injured workers unattended or in the care of fellow workers. Many injured workers were transported to hospital by private vehicles.)

6. No Ambulances should ever be used as a command post.

   (Background to the recommendation: Evidence showed that one of the ambulances that responded to the explosion and fire on April 23, 2012 was used strictly as command post.)

To: **Minister of Jobs, Tourism, Skills and Training**

7. Amend s. 130 of the Workers' Compensation Act to ensure that the joint occupational health and safety committee reviews any changes to equipment/machinery or process to assess impacts on workers' health and safety.

   (Background to the recommendation: The inquest heard that regular evaluation of process hazards is important to ensure potential risks to workers are identified, particularly when process or equipment is changed.)

8. Construction of new mills as well as sawmill refits or upgrades should be made to the highest possible standards.

   (Background to the recommendation: A good example is the current Lakeland mill recently built by the Sinclar Group in Prince George, BC.)

9. Clarify the meaning of the term "participation" in s. 174 of the Workers Compensation Act to ensure full and meaningful participation in the investigative process by both the employer and the worker representative.

(Background to the recommendation: The inquest heard that access to the Lakeland mill site by the employer's representative and a worker representative was denied or limited, hampering the employer's ability to comply with s. 175 of the Workers Compensation Act.)

10. Review s. 175 and s. 176 of the Workers Compensation Act to determine whether employer investigations are required.

    (Background to the recommendation: The inquest heard that the employer did not prepare an Incident Investigation Report as required by the Workers Compensation Act.)

11. Amend s. 172 of the Workers Compensation Act to ensure that an employer must immediately notify the Board of any fire or explosion that causes a business interruption.

    (Background to the recommendation: The inquest heard that there were two significant explosions/fires at Lakeland mill in January 2012, neither of which was reported to WorkSafeBC or fire officials. Evidence indicated that near misses should be treated as important opportunities to consider and alleviate risks.)

To: **Minister of Justice**

12. Ensure that the BC Fire Code and all other provincially mandated codes are freely available in the same manner as provincial Statutes and Regulations.

    (Background to the recommendation: The jury heard that, though compliance with the Fire Code is mandatory, it is not available to view or access online except at a cost.)

13. Amend the Fire Services Act to create penalty provisions for non-compliance with the BC Fire Code and orders of the Fire Commissioner.

    (Background to the recommendation: The inquest heard that the Fire Commissioner cannot impose penalties for non-compliance with the Fire Services Act or the Fire Code making enforcement very difficult.)

14. Provide the Fire Commissioner authority to set minimum standards for qualification and training of Fire Prevention officers consistent with U.S. National Fire Prevention Association level 1 standards or higher.

(Background to the recommendation: The inquest heard that there is no formal training requirement for Fire Prevention Officers.)

15. Ensure the Office of the Fire Commissioner has an Information Management System capable of effectively receiving, analyzing and disseminating information in support of evidence-based decision making.

    (Background to the recommendation: The inquest heard that the Office of the Fire Commissioner has limited ability to record, analyze or report statistical information about fires and that this information is not available to view on-line.)

To: **Office of the Fire Commissioner**

16. Implement recommendations #4, #5, #6 of the BC Safety Authority Investigation Report into the Lakeland Mills Ltd. Explosion and Fire.

To: **WorkSafeBC**

17. Implement an audit tool to measure the effectiveness of joint health and safety committees and ensure inspection officers audit an employer's joint health and safety committee when WorkSafeBC inspections are conducted.

    (Background to the recommendation: The inquest heard that there is currently no oversight by WorkSafeBC of whether a joint occupational health and safety committee is active or effective.)

18. Maintain the Fire Inspection Prevention Initiative (FIPI) beyond the 2016 termination date.

    (Background to the recommendation: It is a beneficial communication tool.)

19. Require employers in the wood industry to provide access to local Safety Committee Minutes to Fire Prevention Officers upon request.

    (Background to the recommendation: To review possible fire hazards.)

20. Establish minimal mandatory training and education for joint occupational health and safety committee members.

(Background to the recommendation: The inquest heard there is no minimum training required for chairs or members of joint occupational health and safety committee members though they are entitled to 8 hours annual educational leave.)

21. There needs to be a heavier emphasis on workers' rights and that the worker has the right to refuse unsafe work.

    (Background to the recommendation: The inquest heard evidence that workers continued to perform their duties even though it was unsafe to do so.)

22. Look into the possibility of installing automatic air quality sensors to monitor dust levels, in facilities where dust hazards may exist so employees are aware of the dust levels.

23. Maintain a public record of all accidents reported under s. 172 of the Workers Compensation Act.

    (Background to the recommendation: the inquest heard that maintaining a public record of accidents helps other employers and workers identify and minimize risks.)

24. Host an annual meeting of representatives of the wood products manufacturing sector, including employers, worker representatives and technical experts to share health and safety results, performance and best practices.

    (Background to the recommendation: the inquest heard that a round-table of influential and committed representatives can share information about risks or improvements to health and safety to ensure better outcomes for workers.)

25. Implement an initiative to ensure all wands used in a combustible dust environment are properly grounded.

    (Background to the recommendation: The inquest heard that wands create static electricity capable of igniting an explosion in a combustible environment. Grounding eliminates this hazard.)

To: **City of Prince George**

26. Establish a bi-annual multi-agency emergency response exercise that includes all emergency and primary responders.

(Background to the recommendation: The inquest heard that there were communication and coordination challenges with the emergency responders attending Lakeland Mill on April 23, 2012 and that regular multi-agency exercises do not occur.)

To: **Sinclar Group Forest Products Ltd.**

27. Ensure that every manager at Lakeland Mill is appropriately trained and qualified for their respective roles and that each manager be required to participate in on-going professional management development.

(Background to the recommendation: The inquest heard that Lakeland Mills management was not responsive to concerns being raised by workers and did not always have the skills or training necessary to effectively manage their teams and work with other managers.)

To: **Manufacturers' Advisory Group and the BC Forest Safety Council**

28. Minutes of all mill Safety committee meetings and investigations must be forwarded and read by all supervisors, superintendents, managers and mill owners.

29. Mills must ensure that there are enough millwrights, mechanics, electricians, and clean-up staff to keep up with the daily demands of mill operation. Inspections, repairs, maintenance and clean-up should not be allowed to fall behind.

30. There should be "Safety Watch Person" on every shift to continually monitor dust systems, vacuum systems conveyors and electric motors.

31. Implement recommendations #1, #2 and #3 of the BC Safety Authority report into the Lakeland Mills Ltd. Explosion and Fire.

To: **Minister of Justice and Attorney General of Canada**

32. Refer the criminal negligence provisions of the Criminal Code to the Standing Committee on Justice and Human Rights to review the onus of proof in cases of criminal negligence involving incidents of bodily harm or death in the workplace.

    (Background to the recommendation: The inquest heard that it was very difficult to successfully prosecute bodily harm and death in workplace incidents.)

To: **Canadian Standards Association**

33. Implement recommendations #7 and #8 of the BC Safety Authority Investigation Report into the Lakeland Mills Ltd. Explosion and Fire.

Ministry of Justice

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File No.:2012:0607:0045

ROCHE	GLENN FRANCIS
SURNAME	GIVEN NAMES

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before: Lisa Lapointe, Presiding Coroner.

into the death of ROCHE (Last Name) Glenn (First Name) Francis (Middle Name) 46 (Age) X Male ☐ Female

The following findings were made:

Date and Time of Death: April 24, 2012 20:43 hours

Place of Death: University of Alberta Hospital (Location) Edmonton, Alberta (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Multi system organ failure

Due to or as a consequence of

Antecedent Cause if any: b) 90 percent total body surface burn with inhalational injury, not compatible with survival

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: x Accidental ☐ Homicide ☐ Natural Suicide ☐ Undetermined

The above verdict certified by the Jury on the 14 day of May AD, 2015

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