

June 9, 2015

**RECEIVED**

**JUN 16 2015**

Lisa Lapointe, Chief Coroner  
Chief Coroner's Office  
Metrotower II Suite 800 – 4720 Kingsway  
Burnaby, BC  
V5H 4N2

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

Dear Ms. Lapointe,

**Re: Jury Recommendations- Lakeland Mills (File 2012:0607:0044/0045)**

On May 14, 2015 the inquest jury into the deaths of Alan Harvey Little and Glenn Francis Roche released 33 recommendations aimed at preventing future incidents in wood processing facilities. These recommendations are a welcome addition to the efforts of numerous entities and individuals to promote safety in these facilities in response to the catastrophic events in two sawmills in early 2012.

This letter is to advise the coroner's office of the status of the jury recommendations that involve BCSA, and to reaffirm our commitment to working with facility operators and others to promote safety in this area.

***Jury Recommendation No. 31***

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

**Part A: Recommendations to Owners and Operators of Wood Processing Facilities**

**BCSA Recommendation #1**

*Document a facility assessment to identify hazardous locations that is completed:*

- *by a professional that is qualified to identify combustible dust hazardous locations, and*
- *in accordance with a recognized industry standard for combustible dust hazardous locations.*

.../2



BCSA Recommendation #2

Where hazardous locations are identified and contain regulated equipment, document a plan to either:

- develop and implement auditable wood dust management practices for these locations that are accepted by a qualified person as an effective means to manage the combustion hazard, or
- configure the equipment for safe operation given the presence of the combustible dust hazard. Safe operating configurations include:
- obtaining approval for operation in the hazardous location, or
- permanent removal of the equipment from the hazardous location.

BCSA Recommendation #3

Incorporate any identified hazardous locations and the chosen means to manage the combustion hazards into the facility's Fire Safety Plan, or other suitable facility document(s).

Status

BCSA issued safety order SO-EL/GA 2013-02 on May 7<sup>th</sup> 2013 (the "Safety Order") requiring owners and operators of wood processing facilities to conduct an assessment of their facility:

- by a qualified professional(s) and
- in accordance with a recognized industry standard to classify and record hazardous locations.

BCSA safety officers have visited all 237 facilities affected by the Safety Order to assess compliance. BCSA has prioritized 138 facilities for follow-up assessments in 2015 based on compliance levels observed on initial attendance.

BCSA will continue to assess the state of compliance in future years and devote resources as required.

**Jury Recommendation No. 16**

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

**Part B: Recommendations to the BC Office of the Fire Commissioner (OFC)**

Recommendation #4

Publish a list of professional qualifications suitable for individuals who identify wood dust combustion and explosion hazardous locations in an industrial environment.

## Status

Although OFC was unable to provide a definitive response prior to BCSA's issuance of the Safety Order in May 2013, we developed our own guidance with the assistance of NFPA combustible dust instructors and industry stakeholders. OFC advised in September 2014 that it does not consider this matter within its statutory authority or mandate.

While BCSA is accordingly no longer pursuing this recommendation with OFC, we continue to believe that the BC wood manufacturing industry would benefit from a practical means to certify individuals to conduct such facility assessments and combustion prevention inspections.

## Recommendation #5

*Identify suitable fire and explosion prevention guidance material to be used in BC for the identification and classification of hazardous locations due to combustible wood dusts.*

## Status

As with the preceding recommendation, BCSA was unable to obtain this material from OFC but did develop its own material with the assistance of NFPA combustible dust instructors and industry stakeholders. BCSA also coordinated with FIPI (BCSA, WSBC, OFC and Industry Stakeholders) to ensure this guidance was included in training materials and consistent with the expectations of other participants.

While BCSA is no longer pursuing this recommendation with the OFC, we believe that the BC wood manufacturing industry would benefit from further development of fire/combustion prevention standards that are specific to the needs of the wood manufacturing industry.

## Recommendation #6

*Add details of a qualified person and accepted guidance material related to hazardous location classification and management into the Fire Safety Plan requirements of the BC Fire Code.*

## Status

OFC advised in September 2014 that it does not consider the definition of "qualified person" within its statutory authority or mandate, and had already implemented guidance on *Fire Safety Plan* requirements.

While BCSA is no longer pursuing this recommendation with the OFC, we believe that these clarifications would be useful given the number of references to hazardous locations and electrical code compliance within Part 5 of the Fire Code.

### ***Jury Recommendation No. 33***

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

### **Part C: Recommendations to the Canadian Standards Association**

#### **Recommendation #7**

*Specifically identify wood dust as a combustible dust belonging to group G dusts in section 18 of the Canadian Electrical Code, Part 1.*

#### **Status**

In June of 2013, BCSA representatives presented the report findings and recommendations to the CSA electrical code Committee (Part 1) which is responsible for revising the code. The Committee responded with support and intent to address the recommendations in subsequent code revisions. BCSA is a member of this Committee.

The draft *Canadian Electrical Code* revisions were published in January 2015 with enhanced definitions of “dust” and “explosive dust atmosphere” which are based on International standards. Although wood dust is not specifically referred to in Group G as sought in the recommendation, in effect the Safety Order has made this interpretation binding in BC wood processing facilities so that the intent of this recommendation is already enforced. BCSA believes that the published changes to the code will significantly improve industry knowledge of hazardous locations requirements.

Additionally, once the *2015 Code* is adopted in regulation, BCSA’s Provincial Safety Manager, Electrical will issue a Directive to provide further clarity on its interpretation and application to combustible wood dust.

#### **Recommendation #8**

*Improve coordination between section 18 of the Canadian Electrical Code and referenced fire and explosion prevention standards for hazardous location identification and classification.*

#### **Status**

In June of 2013, BCSA representatives presented to the CSA electrical code Committee (Part 1) its findings and recommendations relative to the electrical code. The Committee responded with support and intent to address the recommendations in subsequent code revisions. BCSA has reviewed a draft of the proposed code revisions for 2015, which include substantial revisions to section 18 to harmonize the content with the international standards for hazardous location classification and combustible dust classification. BCSA

believes that these changes will significantly improve the communication and comprehension of electrical requirements in hazardous locations. BCSA will continue to develop and issue guidance materials wherever opportunities for improvement are identified.

***Jury Recommendation No. 18***

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

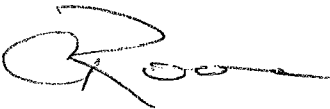
Status

BCSA has advised FIPI that it is prepared to extend its participation in FIPI.

**Conclusion**

We trust this is the information required for the coroner's office to assess implementation of the jury's recommendations and invite you to contact BCSA at any time if further information is required. BCSA will continue its focus on the safety of technical systems in wood processing facilities taking into account the valuable contributions from the coroner's jury.

Yours truly,

A handwritten signature in black ink, appearing to read 'C. Roome', with a stylized flourish at the end.

Catherine Roome  
President & CEO



**BC Forest Safety**  
*Unsafe is Unacceptable*

August 18, 2015

Ms. Lisa Lapointe  
Chief Coroner  
c/o BC Coroners Service  
Office of the Chief Coroner  
Metrotower II  
Suite 800, 4720 Kingsway  
Burnaby, BC  
V5H 4N2

Dear Lisa,

**Re: BCCS Case File #2012-0607-0044 and 2012-0607-0045**

We have received your letter of August 12, 2015 requesting a response to the recommendations from the Coroner's Inquest into the deaths of, Alan Harvey Little and Glenn Francis Roche.

We will put a response together and get back to you per your request.

Sincerely,

Reynold Hert  
CEO

RH/jm



October 23, 2015

Ms. Lisa Lapointe,  
Chief Coroner  
BC Coroners Service, Ministry of Justice  
Metrotower II Suite #800  
4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

**Re: Jury Recommendations - Lakeland Mill (File 2012:0607: 0044/0045) and /  
- Babine Forest Products (File 2012:0612: 0001/0002)**

The Manufacturing Advisory Group (MAG) and the BC Forest Safety Council (BCFSC) are committed to the principle that every worker deserves to go home injury-free at the end of each shift. We therefore thank the jurors, witnesses, families, legal counsel and BC Coroners Service for their participation in the inquests to help further that objective. We also know that one of the best ways we collectively may honour the memories of these four men – Glenn Francis Roche, Alan Harvey Little, Carl Rodney Charlie and Robert Francis Luggi – is by ensuring stakeholders in this matter continue to implement the knowledge, processes and procedures identified to help prevent any similar re-occurrence in the future. MAG and the BCFSC are fully committed to working with the other agencies named in the juries' recommendations to ensure effective solutions are achieved.

This letter serves as our formal response to indicate our views, actions and intended future actions relating to the juries' recommendations specific to MAG and the BCFSC which became the health and safety association for MAG, effective April 1, 2015, on a trial basis until December 31, 2016.

We will ensure that you are kept apprised of the progress that is made in implementing these recommendations.

### **Lakeland Mill**

#### **Jury Recommendations at the Inquest into the deaths of Alan Harvey Little and Glenn Francis Roche:**

**No. 1.** Collaborate to develop a training program with certification to foster active participation in joint health and safety committees.

*MAG and the BCFSC will undertake a comprehensive review of this recommendation in collaboration with the United Steelworkers. MAG companies are fully committed to ensuring active as well as effective participation in joint health and safety committees with the purpose of creating and sustaining workplaces that effectively meet the health and safety needs of all workers.*

**No. 28.** Minutes of all mill safety committee meetings and investigations must be forwarded and read by all supervisors, superintendents, managers and mill owners.



*This is currently best practice and well established in many mills. Mills within MAG have made available prototype minute documents and distribution lists, available via the BCFSC website to assist any of the smaller mills that may not already have these processes in place.*

**No. 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.

*MAG is strongly committed to ensuring that the right resources are in place for the type, size and nature of operations, whether 24-hour or 12-hour operating cycles with different shifts. MAG companies have trained their managers, supervisors and workers to impress upon them that everyone has a continuing responsibility to monitor situations where dust is accumulating beyond acceptable levels as legislated. In addition, all employees have been reminded and are expected to report any unsafe work situation and have the right to stop work if they feel dangerous dust accumulations are occurring. A large percentage of MAG company operations have also incorporated daily inspections of dust accumulation, technology and clean-up efforts by an independent staff member or contractor. These daily inspections have been sustained as a best practice following the conclusion of Phase 5 inspections by WorkSafeBC.*

**No. 30.** There should be a “Safety Watch Person” on every shift to continually monitor dust systems, vacuum systems, conveyors and electric motors.

*As previously noted, everyone has been trained to monitor situations including where dust is accumulating beyond acceptable levels as legislated. In addition, every MAG operation is committed to adhering to the dust management plan established for their operations which includes the monitoring of each piece of equipment to ensure that dust levels are within the pre-defined safety levels. Our view is that there is a stronger system in place with every individual in the mill, management and hourly, essentially trained and monitoring dust as part of their roles.*

**No. 31.** Implement recommendations #1, #2 and #3 of the BC Safety Authority Report into the Lakeland Mills Ltd. Explosion and Fire, which are:

*Recommendation #1:* Document a facility assessment to identify hazardous locations that is completed by a professional that is qualified to identify combustible dust hazardous locations, and in accordance with a recognized industry standard for combustible dust hazardous locations.

*Recommendation #2:* Where hazardous locations are identified and contain regulated equipment, document a plan to either: develop and implement auditable wood dust management practices for these locations that are accepted by a qualified person as an effective means to manage the combustion hazard; or, configure the equipment for safe operation given the presence of the combustible dust hazard. Safe operating configurations include:

a) obtaining approval for operation in the hazardous location, or





b) permanent removal of the equipment from the hazardous location.

*Recommendation #3:* Incorporate any identified hazardous locations and the chosen means to manage the combustion hazards into the facility's Fire Safety Plan, or other suitable facility document(s).

*These recommendations deal with the documentation and identification of hazardous locations and the development of plans to manage dust accumulations around those locations. These recommendations became a safety order which all operations have now met.*

### **Babine Forest Products**

#### **Jury Recommendations at the Inquest into the deaths of Robert Francis Luggi and Carl Rodney Charlie:**

**No. 1.** Ensure that all plants have proper outdoor lighting, a fire pumping system, a stand-alone first aid facility and well identified muster stations. All of these installations should be serviced by a fully functional automatic emergency power system.

*MAG and the BCFSC will undertake a comprehensive review of this recommendation.*

**No. 27.** Compile and make available best practices including life safety engineering related to construction of new wood processing plants and for refitting old plants to address combustible dust issues.

*MAG companies presently share and make available best practices including life safety engineering related to construction of new wood processing plants and for refitting existing plants to address combustible dust issues.*

*MAG has also worked with a number of engineering firms and insurance companies over the past two years and is confident that all new construction and refitting of existing MAG plants will be carried out in such a way to effectively manage and mitigate combustible dust issues. In addition, the MAG Sawmill Dust Audit includes evaluating new and retrofitted construction features, engineered ventilation systems, and mechanical and electrical systems.*

**No. 28.** Encourage employers to utilize the existing Manufacturing Advisory Group dust audit tool regarding combustible dust mitigation.

*MAG companies are required to utilize the MAG dust audit tool as a condition of participating in MAG. In addition, in 2014, the BCFSC in conjunction with the MAG, made available a team of technical expert advisors for all sawmills in BC. The purpose of the initiative was to provide comprehensive support and expertise to the sawmill industry on combustible dust control and mitigation at no cost to the industry. MAG and the BCFSC have worked and continue to work with the various industry associations to encourage employers to utilize the MAG dust audit including making the audit tool available on the various industry association websites.*

**No. 33.** To ensure the effective sharing of information to ensure ongoing risks can be evaluated by all members of the safety community.



**BC Forest Safety**  
*Unsafe is Unacceptable*

**MAG**

Manufacturing Advisory Group

*MAG meets regularly to discuss and share information regarding ongoing risks. To support this sharing and dissemination of information, a section on the BCFSC website is being created as an online resource for industry and others to find relevant, timely information on safety issues facing mills.*

Please contact us if any further information or clarification on the above is required. Our commitment to safety is unwavering, and we thank you for the opportunity to provide this input.

Yours truly,

Ken Higginbotham,  
On behalf of MAG

Reynold Hert, CEO  
BC Forest Safety Council



RECEIVED

JUL 02 2015

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

JUN 26 2015

Ref: 109474

Ms. Lisa Lapointe  
Chief Coroner  
Chief Coroner's Office  
Metrotower II Suite 800 - 4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

*Lisa:*

I am writing to confirm that the Government of British Columbia has received the inquest findings and recommendations issued by the BC Coroners Service jury on May 14, 2015, regarding the deaths of Mr. Alan Little and Mr. Glenn Roche in the 2012 Lakeland sawmill tragedy. As the Minister of Jobs, Tourism and Skills Training and Minister Responsible for Labour, I will take the lead in coordinating the response from the provincial government.

I can assure you that government takes the safety of all workers in British Columbia (BC) most seriously. Government also takes seriously all the recommendations of the inquest jury. We immediately undertook a review of recommendations made to the provincial government and will pursue the steps necessary to ensure that workers are safe in BC. I will ensure that you are kept apprised of the progress that is made in implementing these recommendations. We will do everything we can to prevent this kind of tragedy from happening again.

I wish to extend my thanks to you, your staff and those who sat on the BC Coroners Service jury for all of the dedicated hard work that was required to conduct this inquest and produce these thoughtful recommendations.

Sincerely,

*Shirley Bond*

Shirley Bond  
Minister

RECEIVED

AUG 06 2015

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

Ref: 109922

AUG 04 2015

Ms. Lisa Lapointe  
Chief Coroner  
Chief Coroner's Office  
Metrotower II, Suite 800 - 4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

I am writing today as a follow up to my June 26, 2015, letter in which I outlined my role in leading the government's response to the Coroner's inquest recommendations regarding the deaths of Mr. Alan Little and Mr. Glenn Roche in the 2012 Lakeland sawmill tragedy.

Government is awaiting any recommendations that will be presented to it arising from the inquest into the deaths of Mr. Robert Luggi and Mr. Carl Charlie (at the Babine sawmill tragedy) before confirming with you in detail the actions that government will take in response. However, as an interim measure, I want to take this opportunity to inform you that the Ministry of Jobs, Tourism and Skills Training has now been in contact with all areas of government which are the subject of the recommendations issued in respect of the Lakeland tragedy. I can tell you that significant work is underway to ensure the recommendations are appropriately implemented where possible and practicable. With respect to many of the recommendations, staff are developing legislative, regulatory, and policy options for government's consideration. In other cases, the appropriate areas have already cooperated in an effort to ensure the recommendations can be implemented. For example, WorkSafeBC is actively working with the Office of the Fire Commissioner and the BC Safety Authority to extend the Fire Inspection Prevention Initiative beyond the end of 2016 (related to recommendation #18). In addition, the Ministry of Justice has engaged with RCMP on a protocol for investigations related to workplace death and injury (related to recommendation #3).

As we continue to consider the recommendations issued by the Coroners Service, including those which may flow from the inquest related to the Babine tragedy, please be assured of my commitment to keep you apprised of the progress that is made and, more broadly, of government's commitment to take the concrete steps necessary to further protect the health and safety of workers in British Columbia.

.../2

Ministry of Jobs, Tourism and  
Skills Training and Minister  
Responsible for Labour

Office of the Minister

Mailing Address:  
PO Box 9071 Stn Prov Govt  
Victoria BC V8W 9E2  
Phone: 250 356-2771  
Fax: 250 356-3000

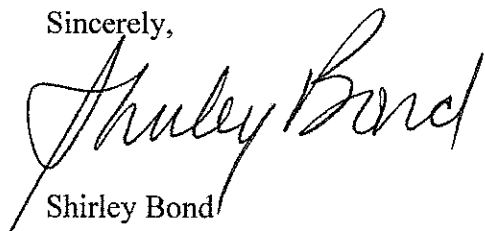
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Room 138  
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Victoria BC

[www.gov.bc.ca/jtst](http://www.gov.bc.ca/jtst)

Ms. Lisa Lapointe  
Page 2

As I said in my previous letter, I wish to extend my thanks to you, your staff and those who sit on BC Coroners Service juries for all of the dedicated hard work that is required to conduct these inquests and produce these thoughtful recommendations.

Sincerely,

A handwritten signature in black ink that reads "Shirley Bond". The signature is written in a cursive, flowing style.

Shirley Bond  
Minister





BRITISH  
COLUMBIA

Ref: 110202

SEP 29 2015

Ms. Lisa Lapointe  
Chief Coroner  
Office of the Chief Coroner  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

Thank you for your letter of August 12, 2015 regarding the findings and recommendations of the Coroner's Inquest into the deaths of Alan Harvey Little and Glenn Francis Roche in the 2012 Lakeland sawmill tragedy.

As Minister of Jobs, Tourism and Skills Training and Minister Responsible for Labour your letter and enclosure brings to my attention the Jury's recommendations #7, 8, 9, 10, and 11. The Jury also issued a number of recommendations to other provincial government ministries and agencies. These include:

- BC Ambulance Service;
- Minister of Justice;
- Office of the Fire Commissioner; and,
- WorkSafeBC.

As you note in your correspondence, the purpose of the Jury's recommendations is to help prevent deaths of a similar nature from occurring in the future. You also request a response that indicates what actions have been taken or are planned with respect to the recommendations.

.../2

As Minister Responsible for Labour, I have assumed the role of coordinating the response to you for all of the Jury's recommendations directed to provincial government ministries and agencies with the exception of WorkSafeBC. While I am the Minister Responsible for WorkSafeBC, they have responded to you directly with respect to the recommendations aimed at it given their independence from government. I understand that these responses will be published on your website and will form part of the official public record in connection with the Jury Verdict.

At the outset, I would like to emphasize on behalf of my colleagues that the matters raised by the Jury's recommendations are very important and that they are matters that I, as Minister Responsible for Labour, and Government take most seriously. We have been deeply moved by the loss experienced by the families impacted in this tragedy, and I have been personally moved by this tragedy as the MLA for the region where it occurred. Our government has made a public commitment to do everything we can to ensure this kind of event never happens again. I hope that when you see our response below, you will agree that we are taking serious action in response to the recommendations.

Responses from the affected provincial ministries and agencies are provided as follows:

**BC Ambulance Service:**

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

**Response:**

BC Emergency Health Services (BCEHS) conducted a thorough internal debrief of the Lakeland incident in 2012 and implemented a number of improvements including:

- Deployment of a combined events radio channel for all first responders so first responders can communicate with each other during a large-scale incident;
- Ongoing incident command training for all staff;
- Increased coordination on responses to large-scale incidents with first responder agencies such as Prince George Fire Rescue.

BCEHS will review the role of its Technical Advisors and how that role interacts with the Incident Command System (and Unified Command). The estimated completion date of this work is October 2015. We will report back to you following this review.



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

Response:

The BCEHS will review its Major Critical Incident response plan and, where possible, adapt the response plan so that patient transport capable vehicles functioning as command posts are replaced with non-transport support vehicles as they arrive on scene. The estimated completion date of this work is October 2015. We will report back to you following this review

**Minister of Jobs, Tourism and Skills Training and Minister Responsible for Labour:**

***Recommendation 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.***

Response:

The Ministry of Jobs, Tourism and Skills Training and Minister Responsible for Labour (JTSTL) is actively considering a legislative amendment to the *Workers Compensation Act* which would clarify the role of joint occupational health and safety committees in reviewing the equipment/machinery or process changes in order to assess the health and safety impacts of such changes. Potential legislation could be introduced as early as fall 2015.

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

Response:

JTSTL understands the Jury's concerns about the need for new sawmills (or sawmill upgrades) to be built to the highest possible safety standards. The Chief Coroner's comment (as background to the recommendation) that the new Lakeland Mill provides an example of a well-built facility is very much appreciated.

Although building/construction standards do not fall within the jurisdiction of JTSTL, I have been assured that recent and ongoing updating of building/construction requirements in British Columbia ensure that our standards appropriately evolve to align with new knowledge and technology respecting the safe and efficient construction of industrial facilities. For example:

- The Building and Fire Codes are essentially harmonized across Canada and provide a level of safety deemed to be socially acceptable and technically possible. The Province continues to support the National Code Development System which continuously reviews these construction standards to confirm they are keeping pace with the growing body of knowledge.



- The *Safety Standards Act* requires that all regulated products and work at sawmill sites, including installation or alteration of electrical systems, complies with adopted codes.
- January 2015 changes to the *Canadian Electrical Code*, planned for adoption by BC this year, further improve safety in combustible dust atmospheres such as wood dust within sawmills.
- The Office of the Fire Commissioner has developed instructional and educational material for use by the industry and inspectors.
- The Office of Housing and Construction Standards advises that the *Building Code* requires registered professionals to design and review large industrial facilities.

***Recommendation 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.***

Response:

JTSTL agrees that where employer and worker representatives are involved in an investigation into an accident, that involvement must be meaningful. JTSTL is actively considering a legislative amendment to the *Workers Compensation Act* which would clarify the role of employer and worker representatives as they participate in investigations under Section 174 of the *Workers Compensation Act*. Potential legislation could be introduced as early as fall 2015.

It should be noted that JTSTL is not prepared to override legitimate reasons for curtailing or delaying an employer investigation (such as where ongoing hazards exist that preclude an immediate investigation or where a criminal investigation is underway) but rather is considering how it could clarify the participation of the employer and worker representative when an employer investigation is proceeding.

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

Response:

JTSTL is pleased that the recent amendments to the *Workers Compensation Act* contained in Bill 9-2015 have addressed this recommendation. In April 2014, Gord Macatee was appointed as Administrator at WorkSafeBC to ensure that necessary reforms were undertaken and specifically, Mr. Macatee was tasked with developing a plan for implementing a world-class inspection and investigation regime, incorporating best practices, workforce review and enhanced training. In accordance with that action plan, issued to government on July 2, 2014, the amendments to Sections 175 and 176 of the Act set out new requirements for preliminary and full investigations by an employer. It is instructive to note that the Bill 9 amendments responded to the following observations made by Mr. Macatee:



*When an incident occurs at a workplace, the main priority should be to ensure that any continuing risks to health and safety are addressed and that the incident does not occur again. The first step in meeting this goal is for the employer to do an investigation to determine the cause of the incident. In order to ensure risks to health and safety are addressed as soon as possible, the employer's investigation must be completed without delay. At the same time, enough time must be provided to ensure that the investigation is thorough, evaluates all factors, and makes an informed conclusion with respect to cause.*

Further actions in support of this recommendation will be taken by WorkSafeBC through its policy on the new legislative provisions, and through its education activities, including notices to stakeholders, new internet resources, inspection guideline documents and information and training sessions.

***Recommendation 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.***

Response:

Under the existing *Workers Compensation Act* provisions, any fire or explosion that has the “potential for causing serious injury to a worker” (even if no injury actually occurs) must be investigated by the employer and the investigation report must be provided to WorkSafeBC. However, adding fires/explosions specifically to Section 172 would require that they also be reported to WorkSafeBC immediately. JTSTL is actively considering a legislative amendment to require the immediate reporting of workplace fire events. Potential legislation could be introduced as early as fall 2015.

**Minister of Justice:**

***Recommendation 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.***

Response:

The Minister of Justice no longer has responsibility for Emergency Management BC or the *BC Fire Code*. Effective July 30, 2015, Emergency Management BC and the Office of the Fire Commissioner were transferred to the Ministry of Transportation and Infrastructure. The Minister of Transportation and Infrastructure appreciates the concern raised by the Jury about public access to the *BC Fire Code*. The basis for the *BC Fire Code* is the *National Fire Code* which is adopted with some variations. As a result, this creates copyright issues when considering how it can be made available. Elsewhere, building and fire codes are typically not available for free. This recommendation will be forwarded for consideration by the Registrar of Regulations as the office with authority governing accessibility and cost-related issues for the *BC Fire Code*.

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

Response:

The *Fire Services Act* is currently under consideration for revision. Recommendation 13 is part of this consideration. The review of the *Fire Services Act* is expected to be completed by February 2016. We will report back to you following this review.

***Recommendation 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 standards or higher.***

Response:

Under the current *Fire Services Act*, Section 3 (3) (b), the Fire Commissioner has authority to set minimum training standards for fire service personnel. However, there is no authority to set minimum standards for fire inspections by non-fire service personnel. The *Fire Services Act* is currently under consideration for revision. This issue is part of this consideration. The review of the *Fire Services Act* is expected to be completed by February 2016. We will report back to you following this review.



***Recommendation 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.***

Response:

The Minister of Transportation and Infrastructure appreciates the concerns raised by the Jury. The current fire reporting system (FIRE) is in need of replacement and cannot be updated. With the recent transfer of Emergency Management BC and the Office of the Fire Commissioner to the Ministry of Transportation and Infrastructure, that Ministry is actively working to identify capital funding to replace the existing FIRE system.

***Recommendation 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.***

Response:

The *Criminal Code* falls within the exclusive legislative jurisdiction of the federal government. If the legal elements of a particular offence are to be reviewed and amended, it is the federal Minister of Justice who must lead the process. The provincial Minister of Justice and Attorney General has responsibility for the administration of criminal justice within British Columbia, but fulfills this responsibility within the context of a criminal law legislative framework that is established federally.

If it assists, I am advised by the provincial Ministry of Justice that in previous recognition of the concern that is now reflected in Recommendation 32, an ad hoc provincial and territorial working group was asked in the fall of 2013 to consider this issue and the group concluded, on balance, that existing legislation, both provincial and criminal, adequately addresses prosecutions and/or the imposition of administrative penalties for workplace fatality and serious injury cases. Provincial regulatory schemes, as canvassed by the working group, generally allow for the imposition of significant penalties when the standard of proof for criminal negligence under the *Criminal Code* is not met.



**Office of the Fire Commissioner:**

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

**#4: Publish a list of professional qualifications suitable for individuals who identify wood dust combustion and explosion hazardous locations in an industrial environment.**

**#5: Identify suitable fire and explosion prevention guidance material to be used in BC for the identification and classification of hazardous locations due to combustible wood dusts.**

**#6: Add details of a qualified person and accepted guidance material related to hazardous location classification and management into the Fire Safety Plan requirements of the BC Fire Code.**

**Response:**

The Office of the Fire Commissioner (OFC) appreciates the Jury's call to move forward on the recommendations contained in the BC Safety Authority Investigation Report. For these recommendations:

#4: The OFC does not have the authority or mandate under the *Fire Services Act* to determine the qualifications of persons, nor does the Act provide any regulatory platform in which to develop a qualification standard. The most appropriate resource to identify a list of registered professionals that specialize in evaluating and engineering solutions to wood dust hazards is the Association of Professional Engineers and Geoscientists of BC (APEGBC).

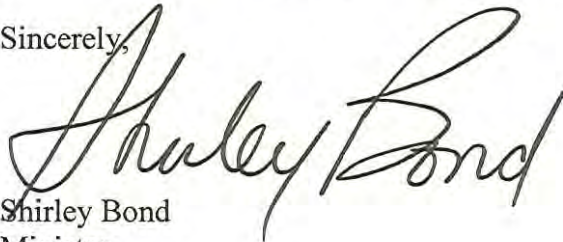
#5: In conjunction with the Fire Prevention and Inspection Initiative, guidance materials to address the identification of combustible dust hazards have been developed and distributed, which are suitable for use in the subsequent identification of hazardous locations. The OFC does not have the expertise to undertake the identification of hazardous locations.

#6: The *BC Fire Code* is substantially based on the National Fire Code of Canada. The Office of Housing and Construction Standards, in collaboration with the OFC, will submit this recommendation to the Canadian Commission on Building and Fire Codes for consideration as part of the cyclical review process.

In closing, on behalf of the Government of British Columbia, I again express condolences to the victims and families of this terrible accident. I would also like to express my appreciation to the members of the Jury who have presented these thoughtful and important recommendations to government for which serious action has been implemented or is being contemplated.

Thank you, again, for your correspondence.

Sincerely,



Shirley Bond  
Minister

pc: Honourable Dr. Terry Lake  
Minister of Health

Honourable Suzanne Anton, Q.C.  
Minister of Justice and Attorney General

Honourable Todd Stone  
Minister of Transportation and Infrastructure

Ms. Athana Mentzelopoulos  
Deputy Minister  
Ministry of Jobs, Tourism and Skills Training and Minister Responsible for Labour

Mr. Stephen Brown  
Deputy Minister  
Ministry of Health

Mr. Richard Fyfe  
Deputy Attorney General  
Ministry of Justice

Ms. Lori Wanamaker  
Deputy Solicitor General  
Ministry of Justice

Ms. Diana Miles  
President and Chief Executive Officer  
WorkSafeBC





RECEIVED

MAR 24 2016

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

Ref: 112383

MAR 23 2016

Ms. Lisa Lapointe  
Chief Coroner  
Office of the Chief Coroner  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

*Lisa*

On September 29, 2015, I wrote to you regarding the findings and recommendations of the Coroner's Inquest into the deaths of Alan Harvey Little and Glenn Francis Roche in the 2012 Lakeland sawmill tragedy.

As Minister Responsible for Labour, I have assumed the role of coordinating the response to you for all of the Jury's recommendations directed to provincial government ministries and agencies with the exception of WorkSafeBC. While I am the Minister Responsible for WorkSafeBC, they have responded to you directly with respect to the recommendations aimed at them given their independence from government.

In the September 29, 2015, letter there were several areas where government committed to updating you with further developments as they unfolded. The purpose of this letter is to provide those updates which apply to several of the recommendations. The updates provided below can be read in conjunction with the formal responses provided in that letter.

**BC Ambulance Service:**

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

.../2



**UPDATE:** BC Emergency Health Services (BCEHS) reviewed the role of its Technical Advisors and how that role interacts with the Incident Command System (and Unified Command). All Technical Advisors are trained to the ICS 300 Level and have completed the BCEHS Multi Casualty Incident (MCI) Triage Course. Further, the BCEHS MCI Course has been reviewed to ensure the training and education is consistent with the Incident Command model and creates interoperability between BCEHS and other agencies. In 2015 BCEHS delivered 42 classes of this course around the province for paramedics, first responders and/or health care professionals from other agencies (police/fire/rescue/health). BCEHS plans to complete another 35 classes before the end of March 2016.

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

**UPDATE:** BCEHS reviewed its Major Critical Incident response plan and did adapt where possible that transport capable vehicles functioning as command posts will be replaced with non-transport support vehicles as they arrive on scene. This change has been adopted into the learning concepts of the BCEHS MCI Course.

**Minister of Jobs, Tourism and Skills Training, and Minister Responsible for Labour:**

***Recommendation 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.***

**UPDATE:** Through the introduction and passing of Bill 35, *Workers Compensation Amendment Act (No. 2)*, 2015, the Ministry of Jobs, Tourism and Skills Training and Minister Responsible for Labour has responded in a very meaningful and direct way to this recommendation.

Bill 35 amended the *Workers Compensation Act* (Act) by adding explicit reference to “significant machinery and equipment” in section 130(g) of the Act. The change is designed to address the coroner jury’s concern that machinery and equipment changes, along with work process changes, should be reviewed by workplace joint occupational health and safety committees.

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

**UPDATE:** No update required based on answer provided in the September 29, 2015 letter.

***Recommendation 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.***



**UPDATE:** Through the introduction and passing of Bill 35, *Workers Compensation Amendment Act (No. 2), 2015*, the Ministry of Jobs, Tourism and Skills Training and Minister Responsible for Labour has responded in a very meaningful and direct way to this recommendation.

Bill 35 amends the *Workers Compensation Act* by providing specific direction in the legislation for what participation of the employer and worker representative in the employer's investigation means. The change is designed to ensure that the employer and worker representatives' participation in investigations is full and meaningful. The amendments specify that, when they are participating in the employer's investigation, the employer and worker representatives may view the accident site with the persons carrying out the investigation. The amendments also specify that employer and worker representatives may give advice on any aspect of the investigation, including the scope and methods of the investigation. Finally, Bill 35 provides WorkSafeBC the authority to prescribe additional activities that may be undertaken by employer and worker representatives. WorkSafeBC is now actively engaged in developing a regulation that will bring further clarification to the participation of worker and employer representatives in employer accident investigations. The regulation development process includes consultation with the worker and employer communities as well as public hearings.

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

**UPDATE:** No update required based on answer provided in the September 29, 2015 letter.

***Recommendation 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.***

**UPDATE:** Through the introduction and passing of Bill 35, *Workers Compensation Amendment Act (No. 2), 2015*, the Ministry of Jobs, Tourism and Skills Training and Minister Responsible for Labour has responded in a very meaningful and direct way to this recommendation.

Bill 35 amends the *Workers Compensation Act* (Act), creating a new requirement on employers to report immediately to WorkSafeBC any accident involving a fire or explosion that had a "potential for causing serious injury to a worker".

Although the Coroner's recommendation refers to reporting fires/explosions which cause "business interruptions", government adopted language more in line with the purpose and context of the *Workers Compensation Act* by requiring immediate notification of fires and explosions that "had a potential for causing serious injury to a worker". That language is used elsewhere in the Act and will allow WorkSafeBC to develop consistent and meaningful policy to assist employers in understanding and carrying out their obligations.



**Minister of Justice:**

***Recommendation 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.***

**UPDATE:** As indicated in the letter of September 29, 2015, the Office of the Fire Commissioner now resides within the Ministry of Transportation and Infrastructure. The responsibility for issues related to the BC Fire Code is delegated to the Building and Safety Standards Branch, Office of Housing and Construction Standards. The BC Building Code (and BC Fire Code) is based substantially on the National Building Code of Canada, which is developed by the National Research Council in Ottawa with the involvement of all provinces and territories. Building and Fire Codes sold in each jurisdiction pay for the cost of the national code development system.

British Columbia, like most other provinces and territories, contributes to the cost of the code development system by respecting the commercial reproduction and intellectual property rights of the National Research Council.

Providing the BC Codes for free would undermine the current funding structure of the code development system.

However, the Building and Safety Standards Branch and the Office of Housing and Construction Standards do have an interest in providing the BC Codes online for free. They have been pursuing this issue for some time now and will continue to explore opportunities within the confines of the established system.

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

**UPDATE:** A new *Fire Safety Act* (Act) was tabled in the Legislature on February 15, 2016, and is currently awaiting second reading. The new Act will repeal and replace the existing Act. The new Act will implement this recommendation to create penalty provisions for non-compliance with the BC Fire Code and orders of the Fire Commissioner.

***Recommendation 14: Provide the Fire Commissioner authority to set minimum standards for qualification and training of Fire Prevention officers consistent with US National Fire Prevention Association level standards or higher.***

**UPDATE:** The new Act that is currently tabled in the legislature provides for the ability to set standards for fire inspectors and fire investigators. The new Act will provide clear authority to set standards for both fire service personnel and civilians in those roles.



***Recommendation 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.***

**UPDATE:** A technical needs assessment is currently underway to identify possible replacements for the existing system and funding has been included in the new 2016/17 budget for a replacement system to be acquired. The new system capabilities will address the issue in this recommendation.

***Recommendation 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.***

**UPDATE:** No update required based on answer provided in the September 29, 2015 letter.

**Office of the Fire Commissioner:**

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

**UPDATE:** No update required based on answer provided in the September 29, 2015 letter.

In closing, on behalf of the Government of British Columbia, I hope that the updates provided in this letter are helpful to the Coroner's office and to the public in understanding the ongoing considerations and actions taken in response to the recommendations flowing from the inquest into the 2012 Lakeland sawmill tragedy.

Sincerely,



Shirley Bond  
Minister

cc: Honourable Dr. Terry Lake  
Minister of Health

Honourable Suzanne Anton, QC  
Minister of Justice and Attorney General

Honourable Todd Stone  
Minister of Transportation and Infrastructure

Ms. Athana Mentzelopoulos  
Deputy Minister  
Ministry of Jobs, Tourism and Skills Training and Minister Responsible for Labour

Mr. Stephen Brown  
Deputy Minister  
Ministry of Health

Mr. Richard Fyfe  
Deputy Attorney General  
Ministry of Justice

Mr. Grant Main  
Deputy Minister  
Ministry of Transportation and Infrastructure

Ms. Becky Denlinger  
Deputy Minister, Emergency Management BC  
Ministry of Transportation and Infrastructure

Ms. Diana Miles  
President and Chief Executive Officer  
WorkSafeBC

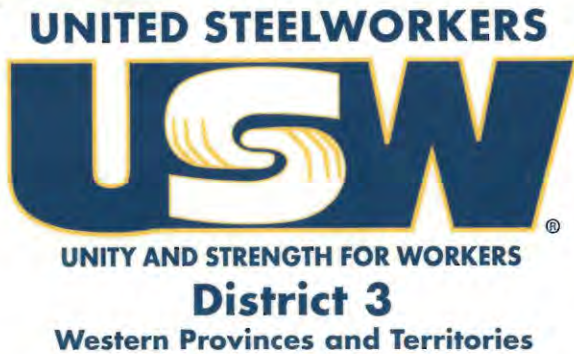


RECEIVED

JUN 23 2015

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

Stephen Hunt  
District Director



June 22, 2015

Lisa Lapointe, Chief Coroner  
Metrotower II Suite 800-4720 Kingsway  
Burnaby, BC  
V5H 4N2

**Re: Verdict at Coroner's Inquest**

I write to respond to the verdict, findings and recommendations into the Coroner's Inquest in the workplace deaths of Glenn Roche and Alan Little dated the 14<sup>th</sup> of May, 2015.

Specifically the jury in recommendation 2 states:

*"The Steelworkers newsletter should be mailed to the homes of workers in the wood manufacturing industry."*

I have directed our communications department to design and implement an efficient system to communicate to members and their families' information that supports our efforts to create societal change that will prevent workplace death, disease and injury. We will look to implement technologies to distribute such publications as the Forest, Safety Network, SafeTalk and other materials directly to families of USW members.

If you have any questions or suggestions please contact me.

Sincerely,

Stephen Hunt  
Director

SH/gt

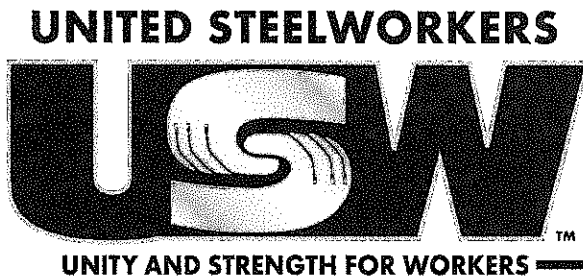
.../continued

Page 2  
June 22, 2015

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Copy: Forest Safety Council  
USW Wood Council Locals, District 3  
RCMP  
BC Ambulance Service  
Minister of Jobs, Tourism, Skills and Training  
Minister of Justice  
Office of the Fire Commissioner  
WorkSafe BC  
Sinclair Group Products Ltd.  
Manufacturers Advisory Group and the BC Forest Safety Council  
Minister Justice and Attorney General of Canada  
Canadian Standards Association

Our ref: 1970-010-1-424-Lakeland  
1640-130 Coroner Inquest



**District 3**  
**Western Provinces and Territories**

**Stephen Hunt**  
District Director

September 10, 2015

**RECEIVED**

SEP 14 2015

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

Lisa Lapointe, Chief Coroner  
Metrotower II Suite 800-4720 Kingsway  
Burnaby, BC  
V5H 4N2

Dear Ms. Lapointe,

**Re: Verdict at Coroner's Inquest**

I write to respond to the verdict, findings and recommendations into the Coroner's Inquest in the workplace deaths of Glenn Roche and Alan Little dated the 14th of May, 2015.

Specifically the jury in recommendation 1 states:

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

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

I have directed our health and safety coordinator to work through the Safety Advisory Foundation for Education and Research (SAFER) Council which has representatives from both the USW and the Manufacturing Advisory Group/BC Forestry Safety Council sitting on it to develop a training program.

Further to recommendation 2 which I have already responded to, enclosed are examples of our communications.

- The USW@WORK magazine is mailed out to all members' homes.
- The SafeTalk newsletter is emailed out to a large health and safety distribution list as well as our regional health and safety directors and local unions.
- The Forest Worker Safety Network (FWSN.ORG) and the Safety Foundation for Education and Research (SAFER.ca) websites are produced and maintained through our office and they continue to bring pertinent health and safety information to our members in the forest industry.

... /2

**Re: Verdict at Coroner's Inquest**

Page 2

If you have any questions or suggestions please contact me.

Sincerely,



Stephen Hunt  
Director

SH/RC/rg  
uswlu2009

CC: Ron Corbeil, USW District 3 HS&E Coordinator  
Forest Safety Council  
USW Wood Council Locals, District 3  
RCMP  
BC Ambulance Service  
Minister of Jobs, Tourism, Skills and Training  
Minister of Justice  
Office of the Fire Commissioner  
WorkSafe BC  
Sinclair Group Products Ltd.  
Manufacturers Advisory Group and the BC Forest Safety Council  
Minister Justice and Attorney General of Canada  
Canadian Standards Association

Our ref: 1970-010-1-424-Lakeland  
1640-130 Coroner Inquest



September 11, 2015

**RECEIVED**

SEP 18 2015

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

Ms. Lisa Lapointe, Chief Coroner  
Ministry of Justice  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby, BC  
V5H 4N2

Dear Ms. Lapointe:

**Re: Jury Recommendations - Glenn Francis Roche and Alan Harvey Little**

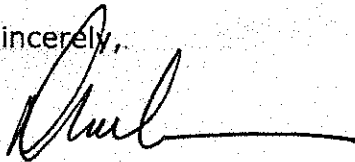
I am writing in response to the inquest recommendations following the tragic deaths of Glenn Francis Roche and Alan Harvey Little. Nine of the thirty-three recommendations from the jury were directed to WorkSafeBC.

As you know we take coroner's jury recommendations extremely seriously and make every effort to respond directly to the recommendation, or, where there are legal limits to our authority and jurisdiction, respond to the spirit and intent of the jury's recommendation.

I am attaching for your information a formal response to each of the recommendations. WorkSafeBC has accepted eight of the recommendations and accepted one recommendation in principle. In regard to the recommendation accepted in principle, the issues relate to the limits of WorkSafeBC's legal mandate.

In accordance with our normal procedure, we will update your office on the progress that is being made.

Sincerely,



Diana Miles  
President & CEO

cc: R. Ellis

Attach.

## Coroner's Inquest Recommendations – Lakeland

Topic	Lakeland
<p><b>Joint Health &amp; Safety Committees</b></p>	<p><b>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.</b></p> <p>(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.)</p> <p><u>Response: Accepted</u></p> <p><i>Sections 125 – 140 of the Workers Compensation Act set out the legal requirements for and duties of joint occupational health and safety committees. Pursuant to the legislation, WorkSafeBC proposes the introduction of an occupational health and safety policy to require the co-chairs of joint occupational health and safety committees to assess the effectiveness of the committee annually and publish the results in the workplace. The policy will provide WorkSafeBC officers with the authority to require evidence that effectiveness audits are being conducted and published.</i></p> <p><i>In consultation with the stakeholders WorkSafeBC will also develop an audit tool.</i></p> <p><i>Non-compliance with the joint health and safety committee requirements of the Act may be subject to employer citations when citations become effective in 2016.</i></p> <p><b>20. Establish minimal mandatory training and education for joint occupational health and safety committee members.</b></p> <p>(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.)</p> <p><u>Response: Accepted</u></p> <p><i>We understand 'minimal' in the recommendation to mean 'minimum'.</i></p> <p><i>In recognition of the breadth of industry and the specific needs of a wide variety of workplaces, the Act sets out the duties and the functions of joint committees in section 130; section 131 states that the joint committee must establish its own rules of procedure. The educational leave section, section 135, as well as setting out the entitlement to annual paid educational leave for committee members also states that WorkSafeBC has a role in either conducting courses for committee members or approving courses.</i></p> <p><i>WorkSafeBC has a wide range of materials that joint committees can access for educational purposes, including:</i></p> <p><a href="http://www.worksafebc.com/publications/health_and_safety/by_topic/assets/pdf/howtoimplement_ohs.pdf">http://www.worksafebc.com/publications/health_and_safety/by_topic/assets/pdf/howtoimplement_ohs.pdf</a></p> <p><a href="http://www2.worksafebc.com/Topics/CertificationTraining/Training.asp?ReportID=35456">http://www2.worksafebc.com/Topics/CertificationTraining/Training.asp?ReportID=35456</a></p> <p><a href="http://www2.worksafebc.com/pdfs/CertificationandTraining/JHSC/JHSC_Responsibilities_Workbook.pdf">http://www2.worksafebc.com/pdfs/CertificationandTraining/JHSC/JHSC_Responsibilities_Workbook.pdf</a></p>



## Coroner's Inquest Recommendations – Lakeland

Topic	Lakeland We will consult with stakeholders on the introduction of an occupational health and safety policy that sets out minimum training standards for committees.
<p><b>Fire Inspection and Prevention Initiative (FIPI)</b></p>	<p><b>18. Maintain the Fire Inspection and Prevention Initiative (FIPI) beyond the 2016 termination date.</b> (Background to the recommendation: It is a beneficial communication tool.) <u>Response: Accepted</u> WorkSafeBC has approved funding to the end of 2016. We are working with the Fire Commissioner's Office and the BC Safety Authority to continue to reap the benefits of the initiative beyond 2016. WorkSafeBC has accepted recommendation #9 of the Macatee Report and pursuant to that is consulting with the FIPI advisory board to identify a permanent host and operational support.</p>
<p><b>19. Require employers in the wood industry to provide access to local Safety Committee Minutes to Fire Prevention Officers upon request.</b> (Background to the recommendation: To review possible fire hazards.) <u>Response: Accepted in principle</u> WorkSafeBC does not have the legal authority to require the wood industry to provide such access; however, pursuant to recommendation #10 of the Macatee Report WorkSafeBC has developed a Memorandum of Understanding with the BC Fire Prevention Authorities, which includes the Office of the Fire Commissioner and the BC Safety Authority and the MOU will provide for the sharing of information in connection with fire events between these agencies and WorkSafeBC.</p>	<p><b>21. There needs to be a heavier emphasis on workers' rights and that the worker has the right to refuse unsafe work.</b> (Background to the recommendation: The inquest heard evidence that workers continued to perform their duties even though it was unsafe to do so.) <u>Response: Accepted</u> Through the combustible dust strategy and other initiatives, WorkSafeBC has focused on increasing understanding of workers' rights and the right to refuse unsafe work in the wood product manufacturing sector. As part of the young and new worker programs, WorkSafeBC includes information on worker rights and the right to refuse unsafe work as part of its ongoing programs and will be creating a new program of youth advocates to raise awareness in schools. Additionally an awareness campaign targeted at young males is being developed in 2015. Going forward, WorkSafeBC will develop further campaigns with Health and Safety Associations and the BC Federation of Labour to provide information and education on employers' responsibilities and workers' rights province wide.</p>

## Coroner's Inquest Recommendations – Lakeland

Topic	Lakeland
Air Quality Sensors	<p><b>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 dust levels.</b></p> <p><u>Response Accepted:</u>  <i>Under the combustible dust strategy and new legally binding dust control policies WorkSafeBC does require employers to manage wood dusts so they do not present a risk of fire and explosion. Employers must perform a risk assessment; they must implement a comprehensive wood dust management program; and they must ensure that program is implemented through a dust mitigation and control audit. Employers are also responsible for training workers in the program that is implemented. While WorkSafeBC does not have the legal authority to require employers to install automatic air quality sensors to monitor dust levels, we will examine this possibility in the OHS guidelines.</i></p>
Accidents Reported – Public Record	<p><b>23. Maintain a public record of all accidents reported under s.172 of the Workers Compensation Act.</b></p> <p>(Background to the recommendation: the inquest heard that maintaining a public record of accidents helps other employers and workers identify and minimize risks.)</p> <p><u>Response Accepted</u>  <i>WorkSafeBC has a searchable data base that identifies reported incidents:  <a href="http://www2.worksafebc.com/Publications/Incidents-Industry.asp?ReportID=36720">http://www2.worksafebc.com/Publications/Incidents-Industry.asp?ReportID=36720</a></i></p>
Annual Industry Meeting and Communication	<p><b>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.</b></p> <p>(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.)</p> <p><u>Response Accepted</u>  <i>The initial meeting of stakeholders was held on May 19, 2015. Meetings that include employers, worker representatives and technical experts will be held annually.</i></p>
Wands – Combustible Dust Environment	<p><b>25. Implement an initiative to ensure all wands used in a combustible dust environment are properly grounded.</b></p> <p>(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.)</p> <p><u>Response Accepted</u>  <i>A WorkSafeBC hazard alert will be updated regarding the safe use of compressed air in combustible dust environments (this includes the use of wands). WorkSafeBC will also fund an independent study on the safe use of compressed air in a combustible dust environment. The results will be broadly disseminated.</i></p>





Suite 2, 1515 Nicholson Street  
Prince George, BC, Canada V2N 1V7

p: 250.563.3423 or 1.800.842.7883 | f: 250.563.6272

[www.sinclar.com](http://www.sinclar.com)

October 1, 2015

Lisa Lapointe, Chief Coroner  
Chief Coroner's Office  
Metrotower II Suite 800 -- 4720 Kingsway  
Burnaby, BC  
V5H 4N2

Dear Ms. Lapointe

Re: Jury Recommendation #27 – Lakeland Mills (BCCS Files 2012:0607:0044 & 2012:0607:0045)

The Lakeland Mills Inquest into the deaths of Alan Harvey Little and Glenn Francis Roche was an important process for understanding the facts of the incident and how all stakeholders can take steps to prevent a similar incident from happening again. The jury's recommendations supported work that has been done by stakeholders while also highlighting areas that require further attention.

This letter is in response to your letter dated August 12, 2015, in which you request our response to the recommendation put forward by the Jury.

**Recommendation #27 directed to Sinclar Group Forest Products Ltd.**

*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.*

Action Taken by Sinclar Group Forest Products

To date we have put all staff through Holloway Zaiser Group training which is focused on providing them with the skills to deal with a returning workforce and a different management team.

These sessions included: Conflict Resolution; Emotional Intelligence; Anger Management; Supervising for Success; Giving and Receiving Constructive Feedback; Dealing with Difficult Conversations; Running Effective



Meetings; Coaching for Leaders; Respect in the Workplace; Delegation; Interest Based Negotiations. In 2016 they will attend "So We've Got Teams – Now What?"; and Skills for High Performance Teamwork.

In addition to the above we have some employees who have gone through Can Scott Training and others who will be scheduled in 2016.

All Staff have gone through the full new hire orientation, whether they were new or an existing employee. They also participate in leading different parts of the orientation process, including various safety modules, i.e. Lockout, Hazard Identification, Dust Control etc.

Lakeland Mills' Human Resources Manager has been and continues to provide one on one coaching with supervisors to assist them in understanding the Collective Agreement, dealing with employee issues, and claims management. In addition the Human Resources group is starting monthly mini-training sessions with staff to address those day to day items that Staff face in their roles as managers.

We have provided "train the trainer" session on Incident Investigations and Root Cause Analysis that a number of Lakeland Mills Supervisors, the Safety/Environmental Coordinator and H.R. Manager participated in. They in turn now spend time coaching other supervisors and safety committee members on incident investigations.

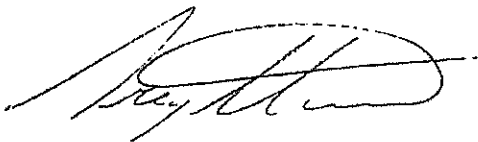
Every manager (supervisors, superintendents & plant manager) are required to complete our online safety training modules.

In May 2015 we held our first Safety Planning Session with the Lakeland Mills Safety Committee which is comprised of both Hourly and Staff members.

Our Safety/Environmental Coordinator graduated in May 2015 from the OH&S program at UNBC.

Sinclar Group is committed to reviewing the training and development provided to all employees to ensure they are qualified for their roles. Please feel free to contact Sinclar Group if you require any further information about our response to recommendation #27.

Sincerely,

A handwritten signature in black ink, appearing to read "Greg Stewart", written in a cursive style.

Greg Stewart  
President



RECEIVED

OCT 15 2015

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

Office of the Chief Coroner  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby, BC, V5H 4N2

Ms. Lisa Lapointe  
Chief Coroner

Dear Ms. Lapointe,

**Re: Coroner's Inquest into the deaths of Alan Harvey Little and Glenn Francis Roche, BCCS Case Files #2012-0607-0044 and 2012-0607-0045**

Thank you for providing CSA Group with a copy of the jury's recommendations regarding the above files and in particular, jury recommendation #33. This recommendation referred to recommendations #7 and #8 from a report issued by the BC Safety Authority; *Investigation Report into the Lakeland Mills Ltd. Explosion and Fire*, hereinafter referred to as BCSA #7 and BCSA #8. This letter outlines our response to those recommendations.

Background information - The Canadian Electrical Code, Part I

The Canadian Electrical Code, Part I (CE Code) is a voluntary standard adopted as regulation by all Canadian Provinces, Territories and Municipalities. It is developed by over 300 volunteer member stakeholders representing all aspects of the Canadian electrical industry through an accredited process facilitated by CSA Group. Each section of the Code is maintained by one of 43 Technical Subcommittees that in turn, report to the Committee on the CE Code, Part I. The Committee on the CE Code is responsible for formal approval of all revisions and interpretations. The CE Code is published on a 3 year cycle with the most recent edition published January 2015.

The CE Code recognizes two systems for classification of hazardous locations, those that are classified by "Zones", and those classified by "Class and Division". Within the 2015 CE Code, requirements for "Zone" classified locations are contained in Section 18 while requirements for "Class and Division" classified locations are contained in Annex J18. It is important to note that Section 18 and Annex J18 do not specify how a location should be classified. Instead, they lay down requirements for hazardous locations that have been classified by a designer, or other person acceptable to the authority having jurisdiction, and in accordance with local regulation.

BCSA recommendation #7

Section 18 of the CE Code (2012 edition) identifies an atmosphere containing flour, starch, or grain dust, and other dusts of similarly hazardous characteristics as a Class II, atmospheric group G hazardous location. While certain wood dusts have "similarly hazardous characteristics", BCSA #7 recommended that the CE Code be updated to specifically include wood dust in the listed examples.

CSA Group response:

This recommendation was forwarded to the Technical Subcommittee on CE Code Section 18 for consideration. The Technical Subcommittee is presently reviewing the recommendation and intends to clarify within the next (2018) edition of the CE Code whether wood dust should be classified as a "dust" or as a "flour".

BCSA recommendation #8

Informative explanatory notes for Section 18 and Annex J18 are contained within Appendix B and Annex JB respectively. BCSA #8 recommended that the following additional reference standards be added to the CE Code with respect to classification of locations that are hazardous due to the presence of combustible dust or flyings:

*NFPA 664, Standard for the Prevention of Fires and Explosions in Wood Processing and Woodworking Facilities, and*

*NFPA 499, Recommended Practice for the Classification of Combustible Dusts and of Hazardous (Classified) Locations for Electrical Installations in Chemical Process Areas*

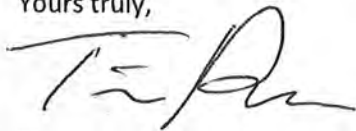
CSA Group response:

Appendix L — *Engineering guidelines for determining hazardous area classifications* first appeared in the 2015 edition of the CE Code. Within that Appendix, clause L14, "Selected references and information sources" includes a reference to NFPA 664, *Standard for the Prevention of Fires and Explosions in Wood Processing and Woodworking Facilities*.

The Subcommittee on Section 18 is presently reviewing a proposal to add a reference to NFPA 499, *Recommended Practice for the Classification of Combustible Dusts and of Hazardous (Classified) Locations for Electrical Installations in Chemical Process Areas*. Any approved revisions resulting from this review will appear in the next (2018) edition of the Code.

Thank you for the opportunity to respond to your report. Please let me know if you have any questions.

Yours truly,



Tim Pope  
Senior Project Manager,  
Canadian Electrical Code, Part I  
[tim.pope@csagroup.org](mailto:tim.pope@csagroup.org)  
416-747-2572

cc. K. Nazarali



DEC 03 2015

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

November 27, 2015

Lisa Lapointe  
Chief Coroner  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby BC V5H 4N2

Cliff#: 1018782  
File#: 51020-50

Dear Ms. Lapointe:

**Re: Coroner's Inquest into the deaths of LITTLE, Alan Harvey and Glen Francis ROCHE  
BCCS Case Files #2012-0607-0044 and #2012-0607-0045**

---

Thank you for your letter regarding the Coroner's Inquest into the deaths of Alan Harvey Little and Glen Francis Roche. BC Emergency Health Services (BCEHS) has reviewed the verdict and the jury recommendations regarding the BC Ambulance Service (BCAS). As a result of this review, we are pleased to provide the following response.

*Recommendation #5: Conduct a review of the Technical Advisor Program to ensure ambulance response is timely and coordinated with an established Incident Command Model.*

BCEHS conducted a thorough review of this incident in 2012, and implemented several recommendations to improve coordination and response for mass casualty incidents. These improvements include the deployment of a combined events radio channel for first responders to allow communication among all responders, ongoing incident command training for all staff, and increased coordination on responses to large-scale incidents with first responder agencies such as Prince George Fire Rescue.

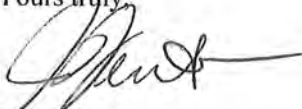
With regard to the comments on the distance of the ambulances to the scene, a BCAS Technical Advisor assessed the scene from the beginning of the incident, and our crews were subsequently staged at an appropriate location. This staging was necessary to maintain the safety of our employees, and was carried out in accordance with our incident command model.

*Recommendation #6: No ambulances should ever be used as a command post.*

We agree this is a good recommendation, and have modified our emergency management response plan for mass casualty incidents so that operational ambulances (if first on scene) will be rotated out of the command post position as soon as support vehicle(s) arrive to support the incident.

Again, thank you for bringing this matter to our attention.

Yours truly,



Jodi Jensen  
Chief Operating Officer



Royal Canadian Mounted Police Gendarmerie royale du Canada

Commanding Officer Commandant divisionnaire

Mail Stop #306  
14200 Green Timbers Way  
Surrey, BC  
V3T 6P3

April 15, 2016

Ms. Lisa Lapointe, Chief Coroner  
Chief Coroner's Office  
Metrotower II  
Suite 800 - 4720 Kingsway  
Burnaby, BC  
V5H 4N2

**RE: Alan Harvey LITTLE and  
Glenn Francis ROCHE  
Coroner's Inquest into the Death of  
2015CP-0214  
BCCS Case Files#: 2012-0607-0044 and 45**

Dear Ms. Lapointe:

As a result of the tragic deaths of Mr. Little and Mr. Roche and injuries to many others in the 2012 Lakeland Mills explosion, we undertook a review of related RCMP Policy and wish to respond to the following Coroner's Jury recommendations directed to the "RCMP":

*Recommendation 3*

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

**Response:**

On April 5, 2014, the RCMP and other British Columbia police agencies signed a detailed Memorandum of Understanding (MOU) with WorkSafeBC whose purpose is "to ensure that the investigation of any work related death or injury is conducted in a thorough, timely and effective manner with a view to the broader public interest as reflected in the respective legislative mandates of the participants." This MOU was further amended later

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**MAY 11 2016**

MINISTRY OF JUSTICE  
OFFICE OF THE CHIEF CORONER

that year as a result of Crown Counsel recommendations flowing from WorkSafeBC's investigation of the Babine Forest Products sawmill explosion at Burns Lake in 2012. The MOU (attached) clarifies roles in, among other things, responding to workplace incidents; investigations; exchange and security of information; and training. Excerpts of the MOU specific to investigation include:

"WorkSafeBC and the Police each recognize that the other has authority to access workplaces and investigate fatalities or serious injuries by way of conducting interviews, seizing evidence and recording information" (4.1)

"While ensuring that potential offences are investigated by the appropriate agency the Police and WorkSafeBC shall consider all offences that could reasonably apply in the circumstances. This includes a consideration of the applicability of Criminal Code ss. 22.1 – 22.3, s. 217.1..." (4.3.1)

"Where practicable and warranted by the nature of the incident being investigated the participants shall use appropriate case management practices which may include major case management methodologies. Such major case management methodologies shall include at a minimum the appointment of a senior investigator to act as a macromanager overseeing the inquiries of both WSBC and the responsible police agency. The senior investigator, consistent with major case management, shall seek the appropriate advice to ensure recognition of both the criminal and regulatory offences that may arise in workplace death and injury cases." (4.6.1)

Comprehensive RCMP "E" Division Operational policies (attached) include:

102.4. Investigation of Serious Incidents

41-3-5 Workplace Accidents and Death

There are currently no RCMP major crime units who specialize in workplace criminal negligence investigations. Instead, the RCMP's investigators rely on a combination of their knowledge of the *Criminal Code*, and its elements of offence, with the highly specialized provincial statutory knowledge of WorkSafeBC's (and others') investigators. And because the criminal investigation of workplace fatalities and serious injuries have since the Spring of 2015 been designated as "benchmark offences" (see Recommendation 4 below), such investigations will not be carried out by general duty police officers but will be commanded by District Senior Investigating Officers, and be carried out by seasoned plainclothes investigators in District Major Crime Units or municipal General Investigative Sections.



As a Joint Investigative Awareness Initiative, the RCMP's Pacific Regional Training Centre is currently developing a multi-agency training video to reinforce the above MOU. The following initiative partners have already been interviewed, and a practice scenario is scheduled to be filmed at a mine in late May:

- RCMP "E" Division Criminal Operations
- RCMP "E" Division Training (R&D/Multimedia)
- Ministry of Energy and Mines
- Municipal Police (represented by the Vancouver Police Department)
- WorksafeBC Investigations
- WorksafeBC Prevention
- WorksafeBC Learning & Development Services

#### *Recommendation 4*

*Include work-site [sic] serious injuries and fatalities as "bench-mark" offences to be reported to the District Senior Investigation Officer.*

#### **Response:**

On May 1, 2015, between the two sitting dates for the Lakeland Mills Inquest, "E" Division RCMP amended its Operational Manual 102.4.7.—Major Crime Investigation and Investigative Guidelines—Investigation of Serious Incidents—Categories of Major Crime to include in its definition of benchmark offences "workplace fatalities and serious injuries." Among other things, this amendment made those incidents reportable to the District Senior Investigating Officer going forward.

Coincident with the above amendments, and by way of reinforcement, "E" Division Criminal Operations published a formal broadcast to all members of the RCMP in British Columbia entitled "Addition to Benchmark Offence List." That broadcast began thus:

"Investigators are reminded that police are responsible for Criminal Investigations when Fatalities and Serious Injuries occur in the workplace and evidence of criminality is present, including criminal negligence by an employer for failing to take reasonable steps to prevent harm under S. 217.1. CCC."

And added, in part:

“Workplace Fatalities and Serious Injuries have now been added to the Categories of Major Crime designated as Benchmark Offences.”

The RCMP is committed to improving its investigative services, and the findings of Courts, Inquiries and Inquests contribute significantly to that improvement. Thank you for bringing these recommendations to my attention.

Respectfully,



A/Commr. Jim Gresham  
OIC Criminal Operations Branch  
Investigative Services and Organized Crime  
“E” Division RCMP



"E" Division Operational Manual

New: 2015-04-02

ROYAL CANADIAN MOUNTED POLICE

## Appendix 41-General-1. MOU - Respecting Investigation of Workplace Fatalities and Serious Injuries

New: 2015-04-02

### MEMORANDUM OF UNDERSTANDING BETWEEN:

The Workers' Compensation Board of British Columbia  
(Hereinafter referred to as "WorkSafeBC")

and:

Abbotsford Police Department  
as represented by the Chief Constable

and

Central Saanich Police Service  
as represented by the Chief Constable

and

Delta Police Department  
as represented by the Chief Constable

and

Nelson Police Department  
as represented by the Chief Constable

and

New Westminster Police Department  
as represented by the Chief Constable

and

Oak Bay Police Department  
as represented by the Chief Constable

and

Port Moody Police Department  
as represented by the Chief Constable

and

Saanich Police Department  
as represented by the Chief Constable



and  
Vancouver Police Department  
as represented by the Chief Constable

and  
Victoria Police Department  
as represented by the Chief Constable

and  
West Vancouver Police Department  
as represented by the Chief Constable  
(Hereinafter referred to as the "Municipal Police Departments")

and:  
South Coast British Columbia Transportation Authority Police Service  
as represented by the Chief Officer

and  
Stl'atl'imx Tribal Police as represented by the Chief Officer  
(Hereinafter referred to as the "Designated Policing Units")

and:  
Royal Canadian Mounted Police  
as represented by the Commanding Officer of "E" Division  
(Hereinafter referred to as the "RCMP")

**RESPECTING  
INVESTIGATION OF WORKPLACE  
FATALITIES AND SERIOUS INJURIES**

**PREAMBLE**

**WHEREAS** WorkSafeBC is created by and charged with the administration of the Workers Compensation Act, R.S.B.C. 1996, c 492 and in particular with the administration of Parts 1 and 3 of the Workers Compensation Act.

**WHEREAS** under Part 1, section 87 of the Workers Compensation Act provides WorkSafeBC with the like powers of the Supreme Court to compel the attendance and examination of witnesses and to compel the production and inspection of books, papers, documents and things; and section 88 of the Workers Compensation Act provides that an officer of WorkSafeBC and every other person appointed to make an inquiry has all the powers conferred by section 87;

**WHEREAS** WorkSafeBC, pursuant to Part 3 of the Workers Compensation Act, R.S.B.C. 1996, c. 492, is mandated to investigate workplace incidents resulting in fatalities or serious injury to workers for the purpose of promoting workplace safety and enforcing the Workers Compensation Act and Occupational Health and Safety Regulation (the "OHSR");

**WHEREAS** under Part 3, WorkSafeBC has been given a number of options to promote

workplace safety which include but are not limited to conducting inspections, investigations, inquiries, writing orders, imposing administrative penalties and referring matters for prosecution under the Workers Compensation Act;

**WHEREAS** the participants recognize that evidence collected for the purpose of a criminal investigation or prosecution under Provincial Statutes, the Workers Compensation Act and the OHSR (a Prosecution or Prosecutions) must be obtained in accordance with the requirements of the Criminal Code of Canada, the Canadian Charter of Rights and Freedoms and criminal and quasi-criminal rules of evidence (referred to collectively as the Prosecutorial Evidentiary Rules);

**WHEREAS** the participants recognize that Part 3, Division 11 of the Workers Compensation Act grants wide powers for purposes of conducting inspections, investigations and inquiries. Evidence gathered using some of those powers whether during an inspection, investigation or an inquiry, although admissible for decisions under the Workers Compensation Act, may not be admissible for purposes of a Prosecution. In view of these limitations, it is important for the participants to be aware that during the course of gathering evidence, the predominant role of WorkSafeBC Officers may evolve intentionally or inadvertently from the consideration of writing orders or potentially imposing administrative penalties to the predominant purpose of evidence gathering for a prosecution. The participants should take the steps necessary to limit the risk of such a change in purpose from compromising a Prosecution;

**WHEREAS** section 179 of the Workers Compensation Act provides officers of WorkSafeBC with authority to enter a place to conduct an inspection or investigation and to require persons to attend and answer questions, take photographs and recordings, require a workplace not be disturbed, take samples and conduct tests of materials and things, require the production of records, and exercise other powers necessary or incidental to carrying out WorkSafeBC Officer's functions; and section 179(5) permits an officer of WorkSafeBC to request the assistance of a Police Officer in carrying out his or her duties;

**WHEREAS** section 172(2) of the Workers Compensation Act provides that the scene of a reportable workplace accident must not be disturbed unless otherwise directed by an officer of WorkSafeBC or a Police Officer;

**WHEREAS** with the exception of violations of the Workers Compensation Act or the OHSR, the Police, pursuant to the Police Act, R.S.B.C. 1996, c. 367 and the Royal Canadian Mounted Police Act, R.S.C. 1985, c. R-10, are mandated to investigate violations of Provincial Statutes and the Criminal Code of Canada, R.S.C. 1985, c. C-46, which result in fatalities or serious injuries;

**WHEREAS** criminal negligence in the workplace can result in fatal and serious injuries and the investigation of any work related death or serious injury should include a consideration of the applicability of Criminal Code ss. 22.1 – 22.3, s. 217.1, and the other "Westray" amendments to the Criminal Code;

**WHEREAS** the participants recognize each other as engaged in law enforcement activities, as those activities relate to privacy legislation under the Freedom of Information and Protection of Privacy Act, R.S.B.C. 1996, c. 165 and the Privacy Act, R.S.C. 1985 c. P-21;

**WHEREAS** sections 33.2(a) and 33.2(i) of the Freedom of Information and Protection of Privacy Act, sections 8(2)(a) and (8)(2)(f) of the Privacy Act, and the 1983 Canada-British Columbia agreement on disclosure of personal information permit the disclosure of personal information: for the purpose for which it was obtained or compiled or for a use consistent with that purpose; and to a public body or a law enforcement agency in Canada to assist in a specific investigation;

**WHEREAS** it is in the public interest that the participants cooperate and share information when conducting concurrent, joint, or sequential investigations into the same incident;

**AND WHEREAS** WorkSafeBC and the Police wish to enter into an agreement for cooperation on activities that enable the participants to carry out their responsibilities in a comprehensive and coordinated manner, without compromising the independence of the participants, and within the provisions of applicable legislative authorities governing privacy and access to information; the following agreement is hereby entered into.

**THE PARTICIPANTS AGREE AS FOLLOWS:**

**1 PURPOSE AND OBJECTIVE**

The purpose of this Memorandum of Understanding (MOU) is to establish a cooperative agreement between WorkSafeBC and the Police to ensure the investigation of any work related death or injury is conducted in a thorough, timely and effective manner with a view to the broader public interest as reflected in the respective legislative mandates of the participants.

**2 DEFINITIONS**

In this Memorandum of Understanding each of the following terms shall, unless the context otherwise requires, have the meaning set out beside it:

**"Chief Constable"** Means any Chief of Police for a Municipal Police Department.

**"Chief Officer"** Means the Chief Officer for the Designated Policing Units.

**"Commanding Officer"** means the Commanding Officer of the Royal Canadian Mounted Police, "E" Division.

**"MOU"** Means this Memorandum of Understanding respecting the Investigation of Workplace Fatalities and Serious Injuries.

**"Police"** Means the provincial police force (Royal Canadian Mounted Police), municipal police departments and designated policing units listed in section 1.1 of the Police Act, R.S.B.C. 1996, c. 367.

**"Police Officer"** Means any sworn member of the Police Department, appointed pursuant to the Police Act and regular members of the RCMP.

**"Prosecution"** Means a prosecution under the Criminal Code, provincial statutes, the Workers Compensation Act or the Occupational Health and Safety Regulation

**"Prosecutorial Evidentiary Rules"** Means the rules of evidence under the Criminal Code, the



Canadian Charter of Rights and Freedoms, and other criminal or quasi-criminal rules of evidence.  
"Provincial Police Service Means the Memorandum of Agreement made between Agreement" or "PPSA"  
the Government of Canada and the Government of British Columbia, dated April 1, 2012.

**"RCMP" or "R.C.M.P."** Means the Royal Canadian Mounted Police, Government of Canada.

**"WorkSafeBC Officer"** Means any Officer appointed by WorkSafeBC.

**"Workplace"** Means any place where a worker is or is likely to be engaged in any work and includes any vessel, vehicle or mobile equipment used by a worker in work.

### **3 AGREEMENT AUTHORITY**

3.1 This MOU is entered into by the Senior Vice President of Worker and Employer Services WorkSafeBC under the authority of the Workers Compensation Act in aiding the administration of justice in the province and in carrying into effect the applicable legislation.

3.2 This MOU is entered into by the Chief Constables of their respective Municipal Police Departments and Chief Officers of their Designated Policing Units located in British Columbia under the authority of sections 26 and 34 of the Police Act to aid in the prevention of crime and offences against the law, and the enforcement of municipal bylaws, the criminal law and the laws of British Columbia.

3.3 This MOU is entered into by the Commanding Officer under the authority of section 5 and in relation to section 20 of the Royal Canadian Mounted Police Act in aiding the administration of justice in the province and in carrying into effect the applicable legislation.

### **4 ROLES IN RESPONDING TO WORKPLACE INCIDENTS**

4.1 WorkSafeBC and the Police each recognize that the other has authority to access workplaces and investigate fatalities or serious injuries by way of conducting interviews, seizing evidence and recording information.

4.2 The Police or WorkSafeBC, on notification of any work related death or serious injury, will notify the other participants as soon as practicable.

4.3 Officers of WorkSafeBC and the Police who attend a workplace incident will each protect the scene for the other and will consult and cooperate as much as possible on issues of site security, interviewing of witnesses, seizing and securing evidence, and exchanging information to ensure the integrity of each agency's investigation.

4.3.1 While ensuring that potential offences are investigated by the appropriate agency the Police and WorkSafeBC shall consider all offences that could reasonably apply in the circumstances. This includes a consideration of the applicability of Criminal Code ss. 22.1 – 22.3, s. 217.1, and the other "Westray" amendments to the Criminal Code.

4.4 If the Police initiate a criminal investigation of the incident, the Police will assume control of the investigation at the scene and may request assistance from WorkSafeBC.

4.5 In the absence of a criminal investigation by the Police, WorkSafeBC will assume control of the investigation at the scene and may request assistance from the Police.

4.6 Where Police and WorkSafeBC have reason to maintain joint control of an incident scene, they may consider entering into a formal Unified Command agreement using the Incident Command System model recognized by all participants in order to facilitate a joint incident action plan and collaboration in other areas of scene management.

4.6.1 Where practicable and warranted by the nature of the incident being investigated the participants shall use appropriate case management practices which may include major case management methodologies. Such major case management methodologies shall include at a minimum the appointment of a senior investigator to act as a macromanager overseeing the inquiries of both WSBC and the responsible police agency. The senior investigator, consistent with major case management, shall seek the appropriate advice to ensure recognition of both the criminal and regulatory offences that may arise in workplace death and injury cases.

4.7 Where Police Officers are first responders to a workplace incident, they will confirm the employer has notified WorkSafeBC and, in the absence of a criminal investigation, will make all reasonable attempts to secure the incident scene undisturbed until WorkSafeBC officers assume control or release the scene.

4.8 Where officers of WorkSafeBC are first responders to a workplace incident and identify that a criminal offence may have occurred, they will secure the scene undisturbed until the Police has assumed control or released the scene.

4.9 WorkSafeBC and the Police each acknowledge that, when attending the scene of a workplace fatality or serious injury, their personnel are subject to the provisions of the Workers Compensation Act, OHSR; and for the RCMP, the Canada Labour Code and regulations under federal legislation. WorkSafeBC and the Police will collaborate in complying with these statutory requirements. In particular, before accessing the scene of an incident, the participants will assess the safety risks and take appropriate precautions to ensure safe entry.

## **5 INVESTIGATIONS**

5.1 WorkSafeBC and the Police may conduct joint or concurrent investigations into a workplace incident and will coordinate activities on such investigations so as to ensure each agency is able to effectively discharge its legal mandate.

5.2 Where there are concurrent investigations underway, neither agency will release any physical evidence it has seized without first advising the other agency and providing an opportunity for that agency to assume control of the evidence.

5.3 WorkSafeBC and the Police will mutually consult and coordinate on the interviewing of witnesses to ensure the integrity of their respective investigations, and avoid unnecessary duplication.

5.4 The Police may request WorkSafeBC technical assistance or expertise for the purpose of

assisting in a criminal investigation of a workplace incident and WorkSafeBC will provide such assistance where possible.

5.5 If WorkSafeBC identifies a potential criminal offence during the course of an investigation into a workplace incident, WorkSafeBC will notify the Police and suspend its investigation until the two agencies are able to consult and exchange information on the matter.

5.5.1 Where WorkSafeBC has identified a potential criminal offence and intends to turn the matter over to the Police under 5.5 or 5.6, both the Police and WorkSafeBC shall seek appropriate legal advice, which may include advice from the Criminal Justice Branch, before the exchange of evidence to ensure that any potential investigation by the Police is not compromised by the receipt of evidence not gathered in compliance with all of the Prosecutorial Evidentiary Rules.

5.6 If the Police do not consider there to be sufficient evidence to initiate a criminal investigation, WorkSafeBC will continue its investigation and any further evidence gathered will be in a manner consistent with the requirements of the Criminal Code of Canada and the Canadian Charter of Rights and Freedoms so as to enable the admissibility of any additional evidence to the Police and Crown Counsel, should it be required at a future date.

5.6.1 Where warranted by the nature of the incident WorkSafeBC, in meeting its obligations under 5.6, may employ major case management methodologies and a dual investigation stream, one for compliance and prevention purposes and the other for prosecutorial investigation purposes.

## **6 EXCHANGE AND SECURITY OF INFORMATION**

6.1 WorkSafeBC and the Police agree to exchange information and records for the purpose of assisting in their respective investigations.

6.2 Where WorkSafeBC or the Police receive notice that it may become, or is, subject to a Court order, summons or subpoena requiring the disclosure of exchanged information or records, WorkSafeBC or the Police shall immediately consult with the originating participant before disclosing the records or information.

6.3 WorkSafeBC and the Police shall not further disclose information and records, exchanged pursuant to this MOU, without the permission of the originating participant, unless the disclosure is for the purpose of and limited to, complying with the legal standard of disclosure in a judicial or administrative law proceeding, or where required by law.

6.4 Despite 6.3, if either WorkSafeBC or the Police, for the purpose of complying with the legal standard of disclosure in a judicial or administrative law proceeding, is required to disclose information or records obtained from the other, the originating participant must be notified prior to any such disclosure.

6.5 WorkSafeBC and the Police recognize that, in the course of an investigation it may be necessary to disclose exchanged information or records to third parties; however, each agrees that such disclosure shall not occur without the prior permission of source agency.



6.5.1 Despite 6.5, WorkSafeBC and the Police recognize that in order to protect the public or persons on worksites from risk of harm, it may be necessary to disclose information that was gathered by one or more of the participants during an investigation. Unless exigent circumstances exist, the participant intending to release the information will, prior to the release of the information, consult with any other participants involved in the investigation.

6.6 All information and documentation provided to, collected by, delivered to or compiled on behalf of the participants to this MOU in the performance of their duties and responsibilities shall be dealt with subject to and in accordance with federal and provincial statutes, particularly the Privacy Act, the Access to Information Act, and the Freedom of Information and Protection of Privacy Act.

6.7 The participants agree that for the purposes of section 13(1) of the Access to Information Act, section 19(1)(c) of the Privacy Act and section 16(1)(b) of the Freedom of Information and Protection of Privacy Act, all information disclosed and received between the participants under this MOU is disclosed and received in confidence.

6.8 Where a participant receives a request under the Access to Information Act, the Privacy Act, or the Freedom of Information and Protection of Privacy Act, or a Court order, summons or subpoena for disclosure of records relating to this MOU, that participant shall consult all other affected participants to this MOU before disclosing the records to the applicant.

## **7 DECISION TO PROSECUTE**

7.1 Police will notify WorkSafeBC as soon as practicable where a police investigation concerning a workplace serious injury or fatality is referred to Crown Counsel for prosecution. Police will notify WorkSafeBC as soon as practicable of Crown Counsel's decision in this regard.

7.2 WorkSafeBC will notify the Police as soon as practicable where a WorkSafeBC investigation concerning a workplace serious injury or fatality is referred to Crown Counsel for prosecution under the Workers Compensation Act. WorkSafeBC will notify Police as soon as practicable of Crown Counsel's decision in this regard.

## **8 COMMUNICATIONS**

8.1 Where there are concurrent investigations, WorkSafeBC and the Police will consult and coordinate on all communications with the victim, the victim's family and the media.

8.2 The participants agree to establish a media relations plan to regulate contacts with the media in relation to this MOU. All media releases shall be reviewed by all affected participants to the MOU before disclosing those media releases to the media and the public.

8.3 Where WorkSafeBC, in the course of an investigation, identifies an existing risk to health and safety that may impact other employers and workers, WorkSafeBC may immediately publicize sufficient information to alert employers and workers of the risk.

## **9 TRAINING**

9.1 WorkSafeBC and the Police will enter into joint training initiatives regarding occupational health and safety and law enforcement investigations.

9.2 WorkSafeBC and Police investigators will undertake training that includes but is not limited to: investigations of criminality in workplace settings; Criminal Code provisions for conducting investigations of workplace serious injuries and fatalities; and procedures and requirements for collecting evidence and writing Reports to Crown Counsel.

## **10 DISPUTE RESOLUTION**

10.1 Disputes between WorkSafeBC and the Police will be resolved jointly by the Director of Investigations Services, WorkSafeBC and the Chief Constable, Chief Officer or Commanding Officer or delegate.

10.2 Police and WorkSafeBC will work cooperatively and will attempt to resolve any matters of disagreements regarding the requirements of Prosecutorial Evidentiary Rules and may contact the Criminal Justice Branch to resolve any areas of disagreement.

## **11 LIABILITY**

11.1 Each participant waives all claims against the other participants in respect of damage caused to its personnel and/or its property by personnel or agents (excluding contractors) of that other participant arising out of, or in connection with, the implementation of this MOU.

11.2 However, if the damage described in section 11.1 results from reckless acts or reckless omissions, willful misconduct or gross negligence of a participant, its personnel or agents, the liability for any costs will be the responsibility of that participant alone.

11.3 If one participant receives notice of a claim by a third party for damage of any kind, caused by one of the participants' personnel or agents arising out of, or in connection with, the implementation of this MOU, the receiving participant will notify the other participants as soon as is practicable.

11.4 In the event of a notice of claim as described in section 11.3, the participants will consult and attempt to resolve the claim. Where appropriate, the participants will divide financial responsibility between themselves to satisfy the claim. If such liability results from reckless acts or reckless omissions, willful misconduct or gross negligence of a participant, its personnel or agents, the liability for any costs will be the responsibility of that participant alone.

11.5 The above provisions of section 11 will survive the termination of this MOU for any reason whatsoever.

## **12 TERM OF THE AGREEMENT**

12.1 This MOU will come into effect when signed by all participants.

12.2 This agreement will remain in effect until replaced by another agreement or terminated in accordance with this agreement.

12.3 In compliance with the Ministerial Directive issued by the Solicitor General of Canada (2002) to the Commissioner of the RCMP that addresses agreements entered into by the RCMP, the participants agree:

- (a) To reviews, audits and evaluations of any aspect of this agreement;
- (b) To amendments by mutual written agreement duly executed by participants to this agreement; and,
- (c) That any of the participants to this agreement may terminate participation in this agreement upon provision of 30 days written notice to the other participants of their intention to terminate this agreement.

12.4 Nothing in this agreement is in any way intended to replace or amend any obligation that any of the participants is bound to or required to perform by operation of law.


12.5 Nothing in this MOU shall be interpreted to conflict with or derogate from the Police Act, Regulations under the Police Act, the Royal Canadian Mounted Police Act, or Royal Canadian Mounted Police Regulations, 1988, but shall be interpreted in all respects to be subject to the Police Act and Regulations under the Police Act, the Royal Canadian Mounted Police Act or Royal Canadian Mounted Police Regulations, 1988. Should any provision of this MOU be found in conflict or derogation of Police Act, Regulations under the Police Act, the Royal Canadian Mounted Police Act or Royal Canadian Mounted Police Regulations, 1988, such provision shall be null and void.


12.6 Nothing in this agreement shall be interpreted as in any way derogating from the responsibilities and obligations of the RCMP pursuant to the Provincial Police Service Agreement entered into between Canada and the Government of the Province of British Columbia, effective April 1, 2012.

12.7 This MOU reflects the good faith and spirit of cooperation of the participants, but is not legally binding on any of the participants.

Original MOU signed October, 2014.

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 [Back to chapter](#)

 New: 2015-04-02

[Important Notices](#)





Royal Canadian Mounted Police / Gendarmerie royale du Canada



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## "E" Division Operational Manual

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**ROYAL CANADIAN MOUNTED POLICE**

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Part 102—Major Crime Investigation and Investigative Guidelines Amended: 2015-05-01 Bulletin

### 102.4. Investigation of Serious Incidents

Originator: Criminal Operations Officer - ISOC. "E" Division

Amended: 2015-05-01

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#### Appendix

"E" Div. OM Appendix 102-4-1 Benchmark Offence Initial Stage Review

#### 1. General

1. 1. A "major incident" is an incident listed in ["E" Div. OM 102.2.2. Reporting](#).
1. 2. The investigation of a major crime/incident sometimes overlaps boundaries of other detachments and/or municipal police agencies.
1. 3. The detachment/unit having jurisdiction of the area where the major crime/incident occurred is responsible for the investigation, unless directed otherwise by the "E" Division CROPS Officer - Investigative Services and Organized Crime or District Commander.
1. 4. Follow procedures at ["E" Div. OM 101.1. Division Reporting Requirements - General](#).

#### 2. District/Detachment/Unit Commander

2. 1. Consider utilizing specialized support units.
2. 2. Ensure that a high level of supervision is maintained throughout the course of a major crime/incident investigation.
  2. 2. 1. Detachment/Unit Supplements should contain the appropriate command, supervisory and review procedures, per Major Case Management investigational standards and principles.

2. 3. Immediately notify the "E" Division Criminal Operations Officer - Core Policing, if you feel that an Independent Officer Review should be initiated regarding the investigation of a major incident. See "E" Div. OM 101.3. Independent Officer Review (IOR).

### **3. OIC "E" Division Major Crime Section**

3. 1. Direct a Division Major Crime Unit to assume control of the investigation into the major crime/incident, after consultation with the District Commander and/or Detachment Commander.

3. 2. Ensure supervisors review the major crime/incident operational files and document their concurrence and/or direction provided.

### **4. Major Crime Unit Commander**

4. 1. Upon receiving a request for assistance, or direction to assume control of an investigation:

4. 1. 1. assess resource requirements;

4. 1. 2. assign investigators as appropriate;

4. 1. 3. establish a coordinated approach consistent with the principles of Major Case Management; and

4. 1. 4. liaise with District/Detachment Commander.

### **5. District Senior Investigating Officer**

5. 1. Each District must have a District Senior Investigating Officer (DSIO) who must be an Accredited Team Commander.

5. 2. DSIO responsibilities:

5. 2. 1. Determine the initial and ongoing categorization of major crimes within your district.

5. 2. 2. Ensure major crime investigations in your district are planned and operated in accordance with:

5. 2. 2. 1. the investigational standards and principles of Major Case Management;

5. 2. 2. 2. related RCMP policy and current best practices; and

5. 2. 2. 3. the command structure for major crime investigations per section 3 below;

5. 2. 3. Ensure lines of enquiry and investigational follow up conform to policy and are relevant to the investigation.

5. 2. 4. Liaise with your District Operations Officer to:

5. 2. 4. 1. ensure efficient resource and cost management practices;

5. 2. 4. 2. determine and allocate appropriate team resources for major crimes investigations;

5. 2. 4. 3. undertake a joint assessment of the investigation and the impact it may have on the local community; and

5. 2. 4. 4. address any other issues he or she deems important to the investigation.

5. 2. 5. Liaise with District Management Team (DMT) and attend DMT meetings regularly.

5. 2. 6. Routinely brief the OIC "E" Div. MCS Detective Superintendent on the investigation.
5. 2. 7. Identify investigations that may require review of the OIC "E" Div. MCS and the District Operations Officer through:
  5. 2. 7. 1. regular survey of PRIME files;
  5. 2. 7. 2. providing briefing notes; and
  5. 2. 7. 3. identification of the cases brought forward by the District Operations Officers, Advisory NCO's and Detachment Commanders.

## **6. Command Structure for Major Crime Investigations**

6. 1. For benchmark offences (see categories of Major Crime below):
  6. 1. 1. The DSIO must be the Team Commander or Monitoring Officer based on the availability of an accredited Team Commander.
  6. 1. 2. Primary responsibility for the investigation remains with the District MCS or the Municipal General Investigation Section (GIS), Regional Traffic Services Unit (CCIT), Regional GIS or, if no GIS exists, with the local detachment.
6. 2. For major incidents, the command structure of the major crime investigation remains separate from the Incident Command structure.
  6. 2. 1. **Exception:** when an operation and a major crime investigation were running in parallel at the time of a major incident (e.g. a major crime occurred in relation to an ERT barricaded person or like critical incident) it will be essential that the DSIO liaises closely with the Incident Commander, as the Incident Commander has responsibility for resolving a critical incident. However the DSIO will have an overall responsibility for the investigation.

## **7. Categories of Major Crime**

7. 1. To assist in command structure and resource allocation, the following categories of major crime are designated "benchmark" offences:
  7. 1. 1. murder/homicide;
  7. 1. 2. high risk (e.g. sex trade workers) missing persons where foul play is suspected;
  7. 1. 3. ransom-based kidnapping; and abductions/kidnaps that appear to be for murder;
  7. 1. 4. suspicious sudden deaths, including sudden infant deaths;
  7. 1. 5. fatal crashes where drivers are unidentified or file remains unsolved (fatal "Hit and Runs");
  7. 1. 6. workplace fatalities and serious injuries; and
  7. 1. 7. other offences at the discretion of the Criminal Operations Officers (Investigative Services and Organized Crime and Core Policing) or the OIC "E" Division Major Crime Section (MCS).

## **8. Formal Review Process**

8. 1. All "benchmark" offences, excluding those offences identified pursuant to above line 7.1.6., will be subjected to a formal review process.
  8. 1. 1. The investigation of workplace fatality and serious injury events will be subject to this Formal



Review process only at the discretion of the Criminal Operations Officer - ISOC, Criminal Operations Officer - Core Policing or the OIC E Division Major Crime Section (MCS).

8. 1. 2. See "E" Div. OM Appendix 102-4-1 Benchmark Offence Initial Stage Review for template.

8. 2. The OIC E Division Major Crime Section, the OIC IHIT, the "E" Division Major Crime Section Operations Officer, the IHIT Operations Officers or the District Operations Officers may identify any other serious incident investigations that should be subjected to a formal review process, at their discretion.

### 8. 3. Roles and Responsibilities

8. 3. 1. The principal objective of any review is to support and to provide assistance to the substantive unit that holds the investigation.

8. 3. 2. The "E" Division Major Crime Section Operations Officer, the IHIT Operations Officer and the District Operations Officers are responsible for appointing a reviewer and determining the terms of reference.

8. 3. 2. 1. The "E" Division Major Crime Section Operations Officer, the IHIT Operations Officer and the District Operations Officers may engage independent advisors to work together with the reviewer and team. In exceptional cases a reviewer from another detachment or the Office of Investigative Standards and Practices may be appointed (e.g. high profile, complex or sensitive issues affecting an investigation).

8. 3. 2. 2. A reviewer should have an investigative background which includes relevant, credible and recent investigative experience.

8. 3. 2. 3. Where practicable, the reviewer should be of at least the equivalent rank to both the Team Commander and Primary Investigator of the investigation subject of the review.

### 8. 4. Stages of the Review Process

8. 4. 1. The reviews are progressive and are made up of four stages:

8. 4. 1. 1. Initial Review (IR);

8. 4. 1. 2. Initial Review Update (IRU);

8. 4. 1. 3. a 5-7 day review; and

8. 4. 1. 4. a 6-8 week review.

#### 8. 4. 2. Initial Reviews (IR's)

8. 4. 2. 1. An IR provides a "high level" account of the investigation as prescribed in the Major Crime Section - Initial Report form ED 6142.

8. 4. 2. 2. IR's are appended in to the investigative file.

#### 8. 4. 3. Initial Review Update (IRU's)

8. 4. 3. 1. An IRU provides a more detailed account of the investigation as prescribed by a Major Crime Section - Initial Report form ED 6142, including volume and type of outstanding tasks, diary dates for analysis, and "way forward" strategy.

#### 8. 4. 4. 5-7 Day Review

8. 4. 4. 1. A 5-7 day review is **NOT** required where the crime is solved i.e. where a strong suspect is identified or there is a clear direction to the investigation.

8. 4. 4. 2. 5-7 day reviews address the following matters:

8. 4. 4. 2. 1. Critical Issues including, Evidence Collection strategy, Victim Liaison strategy, Future Investigative strategy and Suspect strategy;

8. 4. 4. 2. 2. Resource Issues;

8. 4. 4. 2. 3. Structure of investigation; and

8. 4. 4. 2. 4. Areas of organizational risk.

8. 4. 4. 3. The 5-7 day report should be completed within 2 days.

8. 4. 4. 4. The 5-7 day report will be appended to the investigative file.

#### 8. 4. 5. **6-8 Week Reviews**

8. 4. 5. 1. These reviews are designed to:

8. 4. 5. 1. 1. identify possible further investigative leads and opportunities with guidance on how these activities should be pursued;

8. 4. 5. 1. 2. ensure that all areas of specific concern and all investigative opportunities have been identified and a strategy has been developed to progress the enquiry satisfactorily;

8. 4. 5. 1. 3. ensure that any areas identified in previous reviews, where problems have been encountered, are identified, actioned and solutions created;

8. 4. 5. 1. 4. bring to the immediate attention of the investigation any key information discovered during the review process;

8. 4. 5. 1. 5. identify good practice for implementation at Division level; and

8. 4. 5. 1. 6. identify issues requiring remedial action at "E" Division Major Crime Section and at the detachment level.

#### 8. 4. 6. **Reporting and Supervision for 6-8 week reviews**

8. 4. 6. 1. The appointed reviewer will be responsible for the selection of the review team. Members of the team should have relevant and credible experience within their own field of major crime investigation.

8. 4. 6. 2. Key members of a review team should include a forensic advisor and a senior analyst.

8. 4. 6. 3. Before commencing the review, the reviewer will establish contact with the Primary Investigator and Team Commander and request a full briefing. The briefing should include a current situation report on the investigation to date.

8. 4. 6. 4. The 6-8 week report should be completed within 2 weeks.

8. 4. 6. 5. At the conclusion of the review, the reviewer will provide a draft or working copy to the OIC "E" Division Major Crime Section, the appropriate Operations Officer, and the Team Commander of the file for review and consultation.

8. 4. 6. 6. The reviewer then will prepare a final report and will provide a copy to the OIC "E" Division Major Crime Section, the Operations Officer and Team Commander. They will in turn determine any action appropriate based on the findings of the final review.

8. 4. 6. 7. The 6-8 week review will be appended to the file.


**8. 4. 7. Tracking**

8. 4. 7. 1. Files that require review will be tracked by the OIC "E" Division Major Crime Section support personnel for compliance with diary dates and completion.

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**References**

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 Amended: 2015-05-01

[Important Notices](#)

**"E" Division Operational Manual**

Amended: 2015-04-02

**ROYAL CANADIAN MOUNTED POLICE****Appendix 41-3-5 Workplace Accidents and Deaths**

Amended: 2015-04-02

1. In addition to the Coroner Service there are two other agencies that have authorities to be considered when investigating a workplace accident or death:

1. 1. Employment and Social Development Canada (ESDC); and

1. 2. WorkSafeBC.

2. ESDC is responsible for investigating workplace accidents and deaths involving:

2. 1. federal department and Crown Corporation employees (e.g. Canada Post, Canada Revenue Agency, Indian and Northern Affairs, Customs, CSIS, DND, RCMP, etc.);

2. 2. federally regulated commercial enterprises (e.g. aviation and marine industries, airports/aerodromes, banks, interprovincial/international trucking, radio, television, cable, grain/coal/sulphur terminals, armoured car services, etc.); and

2. 3. First Nations (e.g. individuals employed by Band Councils).

3. Pursuant to sec. 15.5 Canada Occupational Health and Safety Regulations an employer must report to ESDC workplace accidents, which result in death or serious injury.

4. ESDC Labour Program toll free number is: 1-800-641-4049.

4. 1. The ESDC line is staffed 24/7 and an Occupational Health and Safety Duty Officer will be immediately contacted to initiate an investigation.

5 WorkSafeBC has a provincial mandate, which covers all work places that are not under the jurisdiction of HRSDC.

5. 1. Pursuant to sec.172 Workers Compensation Act an employer must report to WorkSafeBC work place accidents, which result in death, serious injury or incidents involving major structural collapse.

Monday to Friday 08:30 hrs to 16:30 hrs call: 1-888-621-7233  
After hours call: 1-888-922-4357

Further contact information can be obtained on the WorkSafeBC web site.

5. 2. See "E" Div. OM 41. General. for further information on MOU Respecting Investigation of Workplace Fatalities and Serious Injuries.

6. The scene of a reportable workplace accident must be left untouched except:

6. 1. for rescue work; or



6. 2. to prevent further failures or injuries until an officer of WorkSafeBC or ESDC investigates, or
6. 3. until the Coroner (when death is involved) and WorkSafeBC or ESDC officer grants permission to disturb the scene.
7. Authority to clear the scene and continue operations after a workplace accident is granted by the Coroner (when death is involved) and WorkSafeBC or ESDC.
  7. 1. **Note:** An RCMP officer can issue this authorization on behalf of the Coroner or ESDC, however, cannot act on behalf of WorkSafeBC.
8. If a WorkSafeBC or ESDC officer requests, a peace officer may assist the officer with his/her investigation.
9. If WorkSafeBC or ESDC identifies a potential criminal offence during the course of their investigation they will notify police and suspend the investigation until the two agencies are able to consult.
10. WorkSafeBC and ESDC gather evidence in a manner consistent with the requirements of the Criminal Code and Charter of Rights and Freedoms.

#### 11. **Member**

11. 1. When investigating work place accidents, which result in death, serious injury or incidents involving major structural collapse you must:

11. 1. 1. Assess the situation per section 6. above.

11. 1. 2. Ensure the employer has contacted either WorkSafeBC or ESDC to advise them of the accident in accordance with:

11. 1. 2. 1. ESDC practices and regulations; or

11. 1. 2. 2. WorkSafeBC Health and Safety Emergency and Accident reporting procedures.

11. 1. 3. Where death is involved, investigate per "E" Div. OM 41.3.3.7. Human Deaths - Investigation - Member.

11. 1. 4. If a criminal investigation is required, assume control of the scene and request assistance from WorkSafeBC or ESDC as required.

11. 1. 4. 1. Consider sec. 217.1. CC (Duty of Persons Directing Work) as you investigate.

11. 1. 5. If a criminal investigation is not required, secure the scene until WorkSafeBC or ESDC officers assume control.

11. 1. 5. 1. WorkSafeBC normally has investigators that can attend a work site anywhere in BC within a day while, in more remote locations, ESDC is sometimes unable to attend for several days.

11. 1. 5. 2. If ESDC is unable to attend within a reasonable time, the legal requirement to protect the scene rests with the employer.

11. 1. 6. Notify a WorkSafeBC or ESDC officer that you are the investigator; and

11. 1. 6. 1. conduct the necessary investigation in conjunction with, the assistance of, or in assistance to a WorkSafeBC or ESDC officer and (when death is involved) the Coroner.

11. 1. 7. If asked for direction by employers/employees regarding resumption of operations or clearing the

scene, inform them that WorkSafeBC, or ESDC, and the Coroner (when a human death is involved) must authorize this action.

11. 1. 8. Advise WorkSafeBC or ESDC of all exhibit seizures

11. 1. 9. Prior to submitting evidence for testing or analysis, advise the WorkSafeBC or ESDC officer to give him or her the opportunity to attend the testing or analysis as required.

11. 1. 10. Prior to releasing any seized evidence, notify the WorkSafeBC or ESDC officer and provide him or her the option to assume control of the evidence.


11. 1. 11. In cases of joint investigations, consider consulting with WorkSafeBC or ESDC prior to interviewing witnesses to ensure the integrity of their investigation.


11. 1. 11. 1. Consider joint interviews where appropriate to avoid unnecessary duplication, but only if the investigation is not criminal in nature.

11. 1. 12. Request technical assistance or expertise from WorkSafeBC or ESDC when required.

11. 1. 13. Consult and coordinate with WorkSafeBC or ESDC prior to release of investigational findings to the family of the injured/deceased and/or communication to the media.

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 Amended: 2015-04-02

[Important Notices](#)



**PRINCE GEORGE FIRE RESCUE SERVICE  
ADMINISTRATION**

1111 - 7<sup>th</sup> Ave. | Prince George, BC, Canada V2L 3N8  
p: 250.561.7667 | www.princegeorge.ca

April 23, 2017

Lisa Lapointe  
Chief Coroner  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

**Re: Coroner's Inquest into the deaths of LITTLE, Alan Harvey and Glen Francis  
ROCHE BCCS Case Files #2012-0607 and # 2012-0607-0045**

I offer the following information on behalf of the City of Prince George regarding Coroners Recommendation 26 that the City of Prince George "*Establish a bi-annual multi-agency emergency response exercise that includes all emergency and primary responders*".

The Prince George Fire Rescue Service (PGFRS) is in the final stages of planning a comprehensive, multi-agency exercise. This training session is designed to enhance and improve inter-agency coordination and communication at emergency scenes.

The exercise will build on work that has been underway for several years, including:

- *Quarterly meetings with regional BC Ambulance Service management personnel;*
- *Pre-planning meetings with first-responder agencies in advance of major public events (e.g. large-scale sporting events);*

- *And participation in industry-organized tabletop exercises.*

The event will take place in June, 2017, if permitted by the schedules of the key participants. Otherwise, it will be held in late-September or early October, 2017.

In October 2013, the City of Prince George hosted an emergency operations centre training simulation at the Prince George Conference and Civic Centre. This event also included local first-responder agencies.

Yours truly,

A handwritten signature in blue ink, appearing to be 'John Iverson', written over a faint blue circular stamp or watermark.

John Iverson  
Fire Chief