



**YUKON WORKERS' COMPENSATION
HEALTH AND SAFETY BOARD** **COMMISSION DE LA
SANTÉ ET DE LA SÉCURITÉ
AU TRAVAIL
DU YUKON**

News Release

For Immediate Release
December 14, 2004

Investigation Concluded Into Workplace Fatality

The Occupational Health and Safety branch of the Yukon Workers' Compensation Health and Safety Board has concluded its investigation into the workplace accident on June 17, 2004 that resulted in the death of 55-year-old Bryan Ross Midgett of Whitehorse.

Mr. Midgett, an experienced heavy equipment operator with the Yukon government's department of Highways and Public Works, was killed while a packer was being loaded onto a tilt trailer. The accident took place on the Takhini River Bridge on the Alaska Highway, about 45 kilometres west of Whitehorse.

Investigating safety officers have determined that Mr. Midgett put himself in a dangerous position by standing on a trailer tongue directly in the path of a 20,400 pound packer while it was being loaded. An equally important factor is that the practice appeared to be accepted by co-workers and his supervisor at the time.

Investigators have determined that complacency appears to be the root cause of the accident. They have made six recommendations to improve work procedures, training, equipment and safety culture.

In addition, they have issued one order under the Occupational Health and Safety Act: that the employer conduct an independent audit of its entire safety program and implement and maintain all recommendations from that audit. The employer has appealed aspects of the order but is proceeding with the audit.

"It is important that *all* Yukon workers and employers pay attention to what was learned from this tragic workplace fatality," said Rob McClure, Director of Occupational Health and Safety. "This accident was preventable, and it carries a lesson for all workplaces – do not be complacent about safety procedures."

An executive summary of the investigation report is attached.

Contact:

Becky Striegler

Public Relations Liaison

Yukon Workers' Compensation Health & Safety Board

Tel: 867.667.8695

Email: becky.striegler@gov.yk.ca

FATALITY INVESTIGATION REPORT

**BRYAN MIDGETT FATALITY OF JUNE 17, 2004
YUKON TERRITORIAL GOVERNMENT
HIGHWAYS AND PUBLIC WORKS**

**Investigation by Ossie Venasse, Safety Officer
and Robert Scott, Manager, Inspections & Compliance**

**FILE NUMBER: 3025-35-04
OCTOBER 20, 2004**

PURPOSE

The investigation of this accident has the following three purposes:

- a) to determine the reasons for the accident,
- b) to prevent the recurrence of this type of accident, and
- c) to determine if the duties of the employer, the supervisor, and the workers were carried out under the Occupational Health and Safety Act.

INTRODUCTION

CASUALTY

Name: Bryan Ross Midgett
Date of Birth: January 19, 1949
Occupation: Heavy Equipment Operator (HEO-2)

EMPLOYER

Yukon Territorial Government
Highways and Public Works
Transportation Maintenance Branch
Box 2703
Whitehorse, Yukon Y1A 2C6

EQUIPMENT

Ingersol-Rand Vibrating Drum, Single Drum, Model SP-56DD, Unit #25-003
Aspen Tilt-Trailer, Unit #12-955

ACCIDENT DESCRIPTION

On the afternoon of June 17, about 2 o'clock, Bryan Midgett, a heavy equipment operator with Highways and Public Works lost his life while a packer was being loaded onto a tilt trailer. The fatality occurred near the Takhini River Bridge on the Alaska Highway at kilometre post 1469, about 45 kilometres west of Whitehorse.

Midgett was standing on the trailer tongue as [REDACTED] a heavy equipment operator with Highways and Public Works, drove the packer onto the trailer. The tilt-type deck began to pivot under the weight of the packer as it climbed past the deck's transition point. At that moment, [REDACTED] was alarmed at seeing Midgett in front of [REDACTED] and immediately pulled the control lever in order to abort the deck

landing on the trailer frame. The packer surged toward the front of the trailer as its deck slammed down onto the trailer frame. The packer climbed the deck's built-in load safety stops and continued towards the trailer tongue. It struck Midgett on his back, crushing him between the packer's drum and the truck's tailgate.

INJURY/DAMAGE

Bryan Midgett sustained a fatal crush injury after he was struck by a packer and forced into the tailgate of a gravel truck. The fatality occurred while loading the packer onto a tilt trailer that was hitched to the gravel truck.

EXECUTIVE SUMMARY

CONCLUSIONS

Bryan Midgett placed himself in a very dangerous location by standing on the trailer tongue directly in the path of the 20,400-pound packer while it was being loaded. It appears that he, as an experienced heavy equipment operator, chose this location because it was normal practice.

There were no written procedures for trailer loading and unloading of heavy equipment.

RECOMMENDATIONS

1. Workers should not position themselves in any area where there is a possibility they may be endangered.
2. The employer should adopt and use proper written work procedures for trailer loading and unloading of heavy equipment. The safe distance for clearance on each side of the trailer being loaded and ensuring its deck is level should be prescribed. Specific instructions should be included for guides.
3. Safety accessories on all mobile equipment should be maintained in proper working condition. The hand valve, which controls the hydraulic fluid for the deck cushion rams, was not serviceable. This manufacturer or a registered professional engineer may provide an exemption because of the modifications.

4. Complacency appears to be the root cause of this accident. The employer should take all necessary steps to develop an effective safety culture so that safety becomes an integral part of all activities. Issues such as motivation, accountability, and leadership need to be reviewed and improved.
5. Yukon Territorial Government should adopt a program such as the Certificate of Recognition (COR) to ensure a consistent performance in safety.
6. The employer should ensure that all equipment operators are familiar with the controls and loading procedures for each piece of equipment. Packer operators should be made cognizant of the reversed controls and seating installations. Refresher training should be carried out each Spring before the construction season begins.

OCCUPATIONAL HEALTH & SAFETY ORDERS

The employer failed to implement and maintain a safety program adequate to ensure the safety of its workers in contravention of the Occupational Health and Safety Act, Section 12(1) and 3(1)(a and b).

Obtain an independent audit of your entire safety program, and implement and maintain all recommendations.