Construction Death Review Committee:

Falls from Heights

Annual Report
June 2025

Ontario

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Message from the Lead Coroner

I am proud to be introducing the first annual report of the Construction Death Review. Why “proud” and not “pleased?” Well, I am not pleased because there were 26 tragic deaths reviewed in this report which represents 26 individuals who leave behind families, friends and colleagues. They never came home from work.

But I am proud for many reasons.

I am proud that the construction sector, families and organizations representing them, the government and unions all recognized that these tragic circumstances need to be looked at in a timely and thoughtful way. Considerations to inform change that can impact workplace safety and save lives should not be delayed by several years, especially when we were seeing similar deaths and repeated recommendations from individual inquests.

As Ontario’s Chief Coroner, I do believe that inquests can be an effective approach to systemic issues and result in recommendations that can inform improved community safety. However, I am proud that collectively, we recognized that the approach we were taking with mandatory inquests into construction related deaths was not necessarily the most effective in providing timely recommendations.

Together, we worked together and developed a process of review that is collaborative and provides a forum for industry, labour and safety representatives to participate. At its core, the new Construction Death Review process is about looking into these tragedies together to find answers for families and provide more system-wide recommendations to enhance the safety of construction workers.

Thank you to everyone who participated to inform the process, provide their expertise in the review and create this first annual report. I am very proud of this accomplishment.

Lead Coroner and Secretariat (2025)

Dr. Dirk Huyer
Lead Coroner, CDR
Chief Coroner, Office of the Chief Coroner

Dr. Roger Skinner
Coroner, CDR
Office of the Chief Coroner

Stephen Moore
Manager, CDR
Office of the Chief Coroner

Silvia Iacozza
Executive Lead, CDR
Office of the Chief Coroner

Arpun Pannu
Senior Policy Advisor, Deputy Executive Lead, CDR
Office of the Chief Coroner

Mathilda Smith
Master Level Policy Co-op Student
Office of the Chief Coroner

Indira Stewart
Legal Counsel
Office of the Chief Coroner

Alessandra Hollands
Legal Counsel
Office of the Chief Coroner

Jennifer Reid
Investigator
Ontario Provincial Police/Office of the Chief Coroner

Zoran Kocovski
Investigator
Office of the Chief Coroner

Hina Naqi
Program Administrator
Office of the Chief Coroner

Naomi Kasman
Data Analytics Safety and Health
Office of the Chief Coroner

Advisory Committee Membership (2025)

Brian Alexander
Financial Secretary, Local 793 IUOE
Executive Director, Operating Engineers Benefits Administration Corporation
International Union of Operating Engineers, Local 793

Monica Bienefeld
Director, Strategy & Integration Branch, Prevention Division
Ministry of Labour, Immigration, Training and Skills Development

Eugene Gutierrez *(Associate Member)*
Executive Director
Threads of Life

Shirley Hickman *(Associate Member)*
Past Executive Director
Threads of Life

Darrin Husack
EH&S Manager
CONDRAIN Group and Ontario Sewer & Watermain Association

Michelle Mraz
Director, Operations
Workplace Safety and Insurance Board (WSIB)

Jennifer McKenzie
Director, Stakeholder & Client Engagement
Infrastructure Health & Safety Association

Sean McFarling
General Counsel
Labourers' International Union of North America (LiUNA), Ontario Provincial District Council and Central and Eastern Canada Organizing Fund

Stephen Moore
Manager, CDR
Office of the Chief Coroner

John Serafini
Manager, Health and Safety
Dufferin Construction Company

Carmine Tiano
Director, Occupational Services
Provincial Building & Construction Trades Council of Ontario

Jaimie Todd
Provincial Specialist, Skilled Trades, Fair, Safe & Healthy Workplaces
Ministry of Labour, Immigration, Training and Skills Development

In Remembrance

A. A.[1]

Gianluigi Ambrosino

Antonio Andre

Ismail Atas

Emmanuel Ayettey

Daniel Barrett

Dimitrios Bouzalas

Antonio DaSilva

Neil Despins

Philip Douglas

Connor Engelberts

Ataollah Golshan

Jorge Enrique Hernandez-Lopez

Jose Ibarra

Justin Martin

Tracey Millsop

Young Jun Na

James Oosterhuis

Rude Paulic

Russell (Scott) Poulton

Steven Regular

Justin Schmidt

Paul Tjioe

Jason Veenstra

Gerhard (George) Wall

Michael Wheeler

[1] Name withheld at the family's request.

Executive Summary

This is the first report of the Construction Death Review ("CDR") into construction-related deaths in Ontario. In addition to discussing data from 131 falls from heights deaths that occurred between 2009-2024, the 2024-25 review focuses on the falls from heights deaths of 26 workers between 2017-2023. The findings of the report are a first step toward building a comprehensive, sector-focused root-cause analysis. Seven recommendations are provided.

Chapters 1 and 2 provide the background to understand the context of the report. Chapter 1 explores the development of the CDR process and the steps taken to assemble the CDR Advisory Committee. The review process has demonstrated that engaging experts with significant sectoral experience enhances the analytical ability of the CDR and supports recommendations that are practical, reasonable, and implementable. Chapter 2 provides an overview of the current health and safety environment in the province. It identifies key provincial health and safety partners and highlights the efforts being made to protect the health and safety of workers in Ontario.

Chapter 3 presents a statistical analysis of 131 falls from heights deaths that occurred between 2009-2024, which includes the 26 deaths specifically under review. The report identifies a number of apparent trends that may warrant further exploration, including the disproportionate number of deaths among men over 50, the high incidence of deaths among inexperienced workers, non-compliance with fall protection requirements, and the frequency of deaths occurring from Thursday to Sunday.

Chapters 4 and 5 detail the circumstances of the deaths of the 26 workers under review. Each worker's death was examined by at least two Committee members before broader discussions with the entire Committee, ensuring a diverse range of expertise and perspectives. Following the review, the Advisory Committee identified five key areas for consideration and recommendation:

1. Strengthening Health and Safety Compliance
2. Enhanced Supervision for Workers Working at Heights
3. Worker/Supervisor Education and Training

4. Homeowner and Small Business Education
5. Case Studies in Training Courses.

Under strengthening health and safety compliance, the Advisory Committee recognized effects of experience (both the lack of experience and long-standing experience), a culture of complacency, and adverse working conditions contributing to workers' deaths. In relation to the potential benefit of enhanced supervision, the Committee focused on the importance of fostering a culture of safety in small and sole proprietor businesses and highlighted potential communication and collaboration issues between constructors and subtrades that may impact safety on a work site. The Committee identified potential fall protection compliance challenges relating to worker and supervisor education and explored potential approaches to the sharing of information about health and safety obligations with small businesses and homeowners who take on a constructor role. Finally, the Committee found that the stories of the individuals reviewed in this report speak to the importance of including real-life examples in fall from heights training.

The Advisory Committee offered the following seven recommendations:

Strengthening Health and Safety Compliance

To the Ministry of Labour, Immigration, Training and Skills Development ("MLITSD") and the Chief Prevention Officer ("CPO"):

1. Explore and analyze why non-compliance with the working at heights training and/or fall protection regulatory duties contributed to the 26 deaths under review. Through the learnings from the information obtained and analysis, strengthen strategies to enhance compliance.

Enhanced Supervision for Workers Working at Heights

To the Provincial Labour Management Health and Safety Committee (as appointed under section 21 of the *Occupational Health and Safety Act*):

2. Explore options to enhance supervision on construction projects where workers are working at heights where there are fewer than five (5) workers.

Worker/Supervisor Education and Training

To the Ministry of Labour, Immigration, Training and Skills Development ("MLITSD"):

3. Consider amendment of O. Reg. 297/13 (Occupational Health and Safety Awareness and Training) to require working at heights training to be completed by a supervisor who may supervise a worker using a method of fall protection, to support the requirement that a supervisor be a "competent person" under the *Occupational Health and Safety Act*.

Homeowner and Small Business Education

To the Government of Ontario, the Ministry of Labour, Immigration, Training and Skills Development ("MLITSD"), the Ministry of Municipal Affairs and Housing ("MMAH"), the Ministry of Public and Business Service Delivery and Procurement ("MPBSDP"), the Ministry of Finance ("MOF"), the Ministry of Economic Development, Job Creation and Trade ("MEDJCT") and the Workplace Safety and Insurance Board ("WSIB"):

4. Led by the MLITSD and working collaboratively with the MMAH, the MPBSDP, the MOF, the MEDJCT, the WSIB and others determined as relevant, explore opportunities to develop and distribute clear and accessible information to:

    a. Support individuals registering and establishing a small construction business regarding their health and safety obligations, including those outlined under applicable legislation and regulations; and

    b. Help homeowners engaged in construction projects understand their health and safety obligations, including circumstances when homeowners may become constructors (as defined in legislation) for a project to allow them to make informed decisions.

5. Consider and devise a plan to best distribute the information referenced in this Recommendation through industry partners including, but not limited to, the Infrastructure Health and Safety Association ("IHSA"), home insurance companies, building permit providers and retail stores that sell building materials.

Case Studies in Training Courses

To the Chief Prevention Officer ("CPO"):

6. Consider developing and sharing communication with all Working at Heights training providers, encouraging them to incorporate real-life stories of workers who have experienced falls from heights workplace tragedies into their training. Two (2) examples can be found on the Infrastructure Health and Safety Association ("IHSA") website – Dean Maguire and Micheal Fisher.

Funding

To the Government of Ontario:

7. Approve additional resources and/or funding to support the implementation of Recommendations #1-6.

Chapter 1: Introduction and Overview

The Construction Death Review ("CDR") examines the deaths of workers who have died as a result of an accident occurring in the course of their employment at or in a construction project. Through a comprehensive review of each fatality, and an analysis of multiple deaths in aggregate, the Office of the Chief Coroner ("OCC") hopes to identify opportunities to enhance health and safety to better protect workers in the construction sector.

This review focuses on the deaths of 26 workers who lost their lives while working at heights, a potentially dangerous task for construction workers. As subsequent chapters will demonstrate, Ontario has a robust health and safety system designed to protect construction workers. For a variety of reasons outlined in Chapters 3 and 5, deaths resulting from falls at heights continue to occur at a consistent rate. While the deaths reviewed in this report were the result of an accident, it is important to acknowledge they were all potentially preventable. This report also provides actionable recommendations that, if implemented, will assist the Ministry of Labour, Immigration, Training and Skills Development ("MLITSD"), construction stakeholders, employers, and workers in the sector to make changes to policy and practice to prevent further deaths.

The remainder of this chapter outlines the development of the CDR and explains the review process.

Origins of the Construction Death Review

Background

Until March 2024, construction deaths resulting from accidents, were subject to mandatory inquests. Each death was examined in a quasi-judicial proceeding before a presiding officer and a jury of five Ontarians. At the conclusion of an inquest, the jury was entitled to propose recommendations aimed at preventing further deaths, many of which were directed to the MLITSD, various stakeholder organizations, and, in select instances, individual companies. Though comprehensive, inquests into construction deaths faced challenges related to timeliness and the practicality of

recommendations, highlighting the need for a more responsive and actionable review process.

On March 6, 2024, the *Coroners Act* was amended to require the OCC to conduct yearly coroner-led reviews of construction-related accidental deaths. The legislative amendments were developed collaboratively with government partners, including the Ministry of the Solicitor General and the MLITSD, and involved consultations with sectoral stakeholders. Engaging diverse perspectives was necessary to unlock the experience and sectoral knowledge to permit a more responsive review process, foster a sense of shared commitment and generate support for the CDR process. The move to a death review process was also anticipated to lead to more timely reviews at both the individual and systemic levels, and, as a result of a more inclusive and responsive process, yield more implementable recommendations.

The Review Process

Purpose

The CDR is established under section 10.2 of the *Coroners Act*. Under subsection 10.2 (2), the Chief Coroner may assign one or more coroners (i.e., the "Lead Coroner(s)") to conduct an annual review of all worker deaths in the previous year that were the result of an accident while working at or on a construction project.[1] Subsection 10.2 (4) of the *Coroners Act* defines the scope of the review. The Lead Coroner(s) must:

- Examine the circumstances of each death subject to the review.

[1] Section 1 (1) of the *Occupational Health and Safety Act* (R.S.O 1990, c. O.1) defines "construction" as including "erection, alteration, repair, dismantling, demolition, structural maintenance, painting, land clearing, earth moving, grading, excavating, trenching, digging, boring, drilling, blasting, or concreting, the installation of any machinery or plant, and any work or undertaking in connection with a project but does not include any work or undertaking underground in a mine." "Project", whether public or private, is defined as,
(a) the construction of a building, bridge, structure, industrial establishment, mining plant, shaft, tunnel, caisson, trench, excavation, highway, railway, street, runway, parking lot, cofferdam, conduit, sewer, watermain, service connection, telegraph, telephone or electrical cable, pipeline, duct or well, or any combination thereof,
(b) the moving of a building or structure, and
(c) any work or undertaking, or any lands or appurtenances used in connection with construction.

- To the extent possible, conduct a systemic examination of the circumstances of all deaths subject to the review.
- To the extent possible, identify any common issues among the deaths subject to the review.
- Develop recommendations for the prevention of further deaths.

Under subsection 10.2 (5) of the *Coroners Act*, the Lead Coroner(s) may consult with any person who has information relevant to the review or who may be affected by the review and may require information from any person with knowledge about the deceased person or the circumstances around the death, including family members, co-workers, employers, or worker representative organizations. Furthermore, Lead Coroner(s) may obtain records and writings related to the deaths under review. Finally, subsection 10.2 (6), permits the Lead Coroner(s) to seek assistance from sectoral or subject matter experts in conducting the review.

Timeline

Under subsection 10.2 (1) of the *Coroners Act*, the CDR is conducted annually and generally includes deaths that occurred in the previous calendar year. Subsection 10.2 (11) further states that a report will be released on or before June 30 of the calendar year following the year in which the deaths were reviewed. For example, a death that occurs in 2025 would be reviewed in 2026 and included in the 2027 report.

Accordingly, the CDR operates on a three-year cycle, as outlined in **Figure 1 (see below)**. These three stages occur concurrently. In most cases, reviews are conducted by the CDR after all other investigations and legal proceedings, including trials and appeals relating to charges under the *Occupational Health and Safety Act*, have been completed.

The legislation acknowledges that many deaths are subject to investigation by the MLITSD or the police, or to prosecution. To ensure that these processes are uninterrupted, subsection 10.2 (3) of the *Coroners Act* allows the Chief Coroner to defer the review of a death to a later calendar year if the death is subject to an ongoing investigation, prosecution, or inquest, or if the Chief Coroner determines that it would be inappropriate for the death to be included in the annual review.

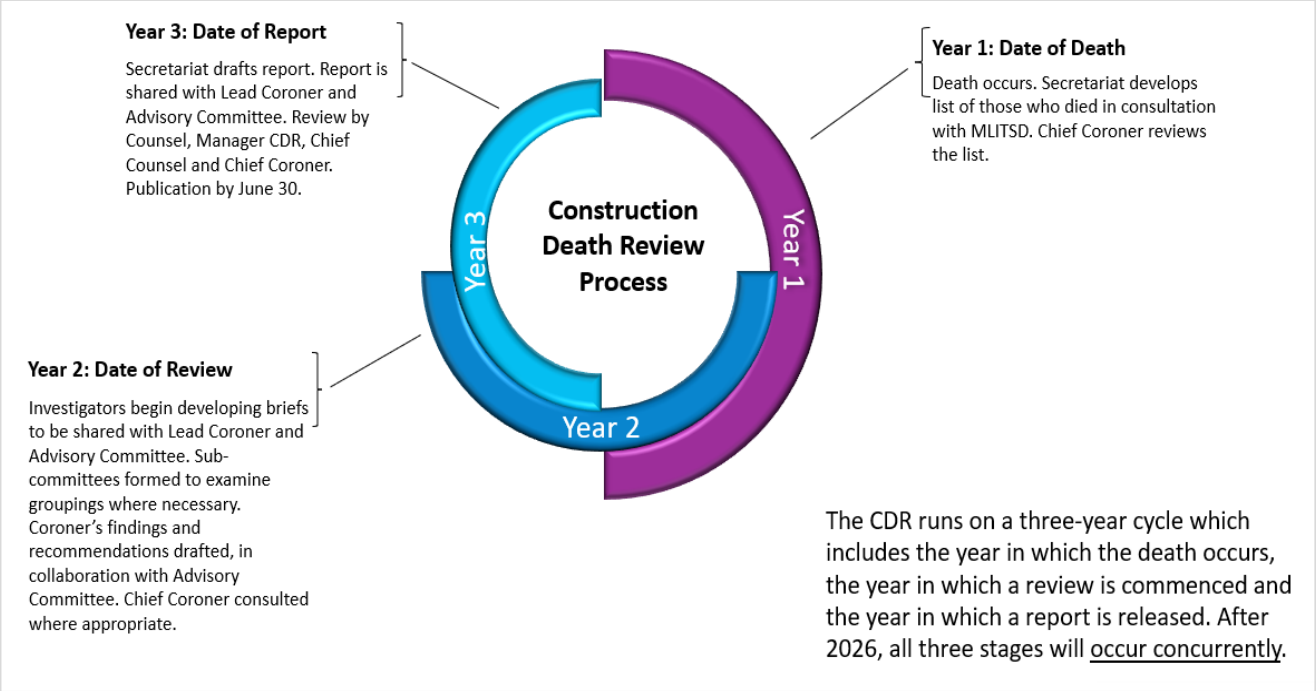

Figure 1: CDR Life-cycle

Conducting a Review

As noted above, subsection 10.2 (5) of the *Coroners Act* permits the Lead Coroner to consult with any person that has information relevant to the review. To ensure a well-informed review and recommendations, the Chief Coroner directed that a committee of sectoral experts be convened to assist with the reviews. The Advisory Committee, appointed by the Chief Coroner, advises the Lead Coroner(s) on relevant issues. It includes 11 members, representing both the OCC and construction sector stakeholders.

The composition of the Committee is:

- One OCC member (Manager, CDR).
- Two members from the MLITSD, representing the Prevention Division and the Fair, Safe and Healthy Workplaces Division.
- Three members from Construction Labour Organizations, recommended by the Provincial Labour Management Health and Safety Committee ("PLMHSC").

- Three members from Construction Ownership Organizations, recommended by the Infrastructure Health and Safety Association ("IHSA"), with at least one affiliated with the PLMHSC.
- Two members from Health and Safety Organizations, including representatives from the IHSA and the Workplace Safety and Insurance Board ("WSIB").

Additionally, one representative from Threads of Life, a non-profit organization committed to supporting families and others affected by a workplace injury, illness, or death, has a standing invitation to provide perspective on issues related to families affected by construction-sector deaths.

Advisory Committee members are invaluable to the CDR. In addition to significant sectoral experience, under the Committee's Terms of Reference, Advisory Committee members are required to have:

- An understanding of and primary focus on the provincial construction sector and its practices.
- Access to skills and knowledge necessary to make recommendations on a broad range of issues, from practical to theoretical.
- An understanding of the existing Health and Safety regime in the province.

Advisory Committee members are appointed for terms of up to three (3) years, renewable for additional terms at the discretion of the Chief Coroner.

To support the CDR process, the OCC has established a Secretariat. Overseen by the manager of the CDR in collaboration with the Lead Coroner(s), the Secretariat includes Legal Counsel, an Executive Lead, a Policy Advisor, an Investigator and a Program Administrator. The Secretariat provides logistic, policy, legal and investigative assistance, ensuring that the CDR operates in accordance with section 10.2 of the *Coroners Act*.

For a more complete overview of the membership and review process, please refer to the Terms of Reference, which can be found in **Appendix A**.

Family Involvement

Family involvement is valued throughout the CDR process and families of deceased workers are encouraged to participate. For instance, family members may be invited to provide information about their loved one, including, but not limited to, a personal statement about their loved one, or information that may be relevant to the circumstances of their loved one's death.

The OCC has developed a process to engage family members throughout the review process. During the review stage, a member of the CDR Secretariat remains in contact with the family to keep them informed about the scheduling and progress of the review, and to explain the purpose and process of the review.

In addition, as noted above, Threads of Life, a Canadian non-profit committed to supporting those affected by workplace injury, illness, or death, holds a standing invitation to provide expertise on issues relating to families impacted by construction-sector deaths.

Chapter 2: The Health and Safety Environment

Ontario has a large and growing construction sector. According to the most recently available data, in 2023, 136,131 individual firms were registered with the Workplace Safety and Insurance Board ("WSIB")[1] and 596,000 full time workers were employed in construction in the province.[2]

Key Stakeholders

Construction has long been considered one of the more dangerous occupations. In 2023, the construction sector accounted for the highest proportion of traumatic deaths amongst Ontario workplaces (~31 percent),[3] yet comprised just 7.5 percent of Ontario's total workforce.[4] As a result, safety in the sector has been a key concern for decades. Ontario has developed a comprehensive occupational health and safety system that brings government and sectoral partners together. The system requires all involved to work together to prevent workplace injuries, illnesses and fatalities, and support the goals of the provincial occupational health and safety strategy.[5]

The **Ministry of Labour, Immigration, Training, and Skills Development** ("MLITSD") oversees and coordinates Ontario's workplace health and safety system. The MLITSD administers the *Occupational Health and Safety Act* ("OHSA") and the regulations made under the OHSA. Where required, the MLITSD also proposes amendments to current legislation and regulations and develops proposals for new legislation and regulations. In addition, the MLITSD inspects workplaces and enforces occupational health and safety law. The MLITSD is also responsible for developing, coordinating and implementing strategies to prevent workplace injuries and illnesses and setting standards for health and safety training.

The MLITSD carries out its prevention mandate in a number of ways. For example, the MLITSD Chief Prevention Officer ("CPO") is tasked with developing a provincial

[1] IHSA Annual Report 2023 at www.ihsa.ca/pdfs/annual_report/2023/ihsa-ar2023.pdf.
[2] https://www.jobbank.gc.ca/trend-analysis/job-market-reports/ontario/sectoral-profile-construction. This represents an 18 percent increase over 2016, when the workforce was 503,700.
[3] https://www.ontario.ca/document/occupational-health-and-safety-ontario-april-2022-march-2023/year-2022-2023.
[4] https://www.jobbank.gc.ca/trend-analysis/job-market-reports/ontario/sectoral-profile-construction.
[5] https://www.ontario.ca/document/prevention-works.

occupational health and safety strategy,[6] providing stewardship and ensuring alignment of prevention activities across all workplace health and safety system partners. The MLITSD also works closely with Ontario's health and safety associations ("HSAs") to ensure effective delivery of prevention programs and services. HSAs are not-for-profit organizations that deliver front-line prevention programs on behalf of the MLITSD, providing services and information to employers and workers.

The MLITSD provides funding (using WSIB funds) and oversight to the Infrastructure Health and Safety Association ("IHSA"), one of the six HSAs designated under the OHSA.[7] The IHSA provides services, information, and training to control and eliminate workplace safety hazards, including in the construction industry specifically.[8] The IHSA is also the only authority in Ontario able to grant the Certificate of Recognition ("COR"), an occupational health and safety accreditation that verifies that an employer has developed and implemented a health and safety management system that meets provincial standards.[9]

MLITSD also administers the Supporting Ontario's Safe Employers ("SOSE") program. This program recognizes and rewards employers who implement and maintain an occupational health and safety management system that meets international best practice standards.[10]

The **WSIB**, an independent agency of the MLITSD funded by 300,000 workplaces across Ontario, provides insurance and other support to more than five million Ontarians.[11] The WSIB provides funding to the MLITSD for the health and safety system, including health and safety prevention activities. The WSIB also funds and operates the Health and Safety Excellence Program for Ontario employers. This program helps participating companies build a health and safety plan, offering rebates to those who meet their goals.

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[6] Find the strategy at Prevention works | ontario.ca.
[7] See Ontario's occupational health and safety system | ontario.ca.
[8] https://www.ihsa.ca/.
[9] https://www.ihsa.ca/cor-home.
[10] https://www.ontario.ca/page/supporting-ontarios-safe-employers-program.
[11] See About us | WSIB.

Prevention-specific advice, including for the construction sector, is provided to the MLITSD through the **Prevention Council**. The Council considers a wide range of occupational health and safety issues, including the appointment of a CPO, the prevention of workplace injuries and illness, changes to the provincial health and safety strategy and changes to the funding and delivery of services related to the prevention of workplace injury.

The Prevention Council is composed of 15 individuals representing an equal number of employer and labour representatives. Not more than one third of the Council is to be composed of non-unionized workers, representatives of the WSIB and persons with occupational health and safety expertise, all appointed by the Minister of Labour, Immigration, Training and Skills Development (the "Minister").[12]

Sectoral representation can also be found on the **Section 21 committees**, including the Provincial Labour-Management Health and Safety Committee – Construction, and the Provincial Labour-Management Safety Committee – Electrical & Utilities. Section 21 committees are appointed by the Minister under section 21 of the OHSA to give sector-specific advice to the Minister on health and safety issues. To ensure that employer and worker needs are met, all current Section 21 committees maintain equal representation from labour and management.[13]

In addition to its official partners, the MLITSD works with, and receives advice from, other organizations and individuals through ongoing and project-specific groups. Other partners include:

- A prevention employer partner advisory table
- Other Ontario ministries
- Non-governmental organizations
- Private sector organizations
- Members of the public

Finally, all **training providers** who wish to provide working at heights training programs must be approved by the CPO. CPO approval ensures that the training

[12] Prevention Council - Public Appointments Secretariat.
[13] Ontario's occupational health and safety system | ontario.ca.

provided will be consistent across all training providers and that participants receive the same type and level of training. As of January 2025, there are currently 176 approved working at heights training providers in Ontario.

Legal Environment

Legislative Changes

The OHSA and its regulations provide the legal framework for the provincial health and safety system. In 2010, an Expert Advisory Panel on Occupational Health and Safety recognized the significant risks faced by construction workers and that "falls from heights continued to be the number one source of fatalities in construction".[14] To address this issue, Ontario introduced new working at heights training requirements in 2015 and has passed several amendments in subsequent years to Ontario Regulations 213/91 (Construction Projects) and 297/13 (Occupational Health and Safety Awareness and Training) to include new sections on ladders, work platforms, and training requirements. An assessment of the 2015 working at heights training requirements by the Institute for Work and Health found that among construction employers with six or more workers, 92 percent were found to be compliant with training requirements.[15] Furthermore, WSIB data showed that the new requirements had a statistically significant impact on the lost-time claim rate, particularly among smaller employers and the sectors with the highest claim incidences.[16] As of April 1, 2024, Ontario has updated the standards for mandatory working at heights training to help improve the quality of training and safety knowledge of participants when working with ladders, skylights, and damaged equipment, among other things.

[14] https://www.ontario.ca/document/expert-advisory-panel-occupational-health-and-safety.

[15] https://www.iwh.on.ca/sites/iwh/files/iwh/reports/iwh_report_wah_evaluation_project1360_final_report_2019.pdf. p. 2.

[16] https://www.iwh.on.ca/sites/iwh/files/iwh/reports/iwh_report_wah_evaluation_project1360_final_report_2019.pdf. p. 2. A study in the September 2020 issue of the *Journal of Safety Research* showed a close to 20 percent decline in the rate of lost-time claim injuries. See Robson et al, "Preventing fall-from-height injuries in construction: Effectiveness of a regulatory training standard," *Journal of Safety Research* 74 (September 2020). However, the study concluded that the impact of a training regimen was modest and "did not eliminate the problem."

Internal Responsibility System

Since 1976, the Internal Responsibility System ("IRS") has been at the core of the OHSA.[17] Simply put, under an IRS, everyone in the workplace has a role to play in keeping workplaces safe and healthy. Workplace parties' compliance with their respective statutory duties is essential to the establishment of a strong IRS. The OHSA lays out the duties of constructors, employers, supervisors, workers,[18] and workplace owners:

Constructor: The general duties of a constructor are found in section 23 of the OHSA. In addition, there are specific requirements for constructors in other sections and regulations under the OHSA, including Ontario Regulation 213/91 (Construction Projects) and Ontario Regulation 420/21 (Notices and Reports under Sections 51 to 53.1 of the Act). Some of the basic requirements and general duties are:

- Ensure that prescribed safety measures and procedures are carried out.
- Ensure that every employer and worker performing work on the project complies with the OHSA and its regulations.
- Ensure the health and safety of workers on the project.
- Appoint a "competent person"[19] as a supervisor if five or more workers are on the project at the same time. Ensure that the project is supervised at all times.
- Ensure that a project lasting more than three months and having 20 or more workers has a Joint Health and Safety Committee ("JHSC").[20]

[17] Dr. James Ham introduced the concept of the Internal Responsibility System to Ontario in the Report of the Royal Commission on the Health and Safety of Workers in Mines.
[18] In 2014, the definition of "worker" in section 1 (1) of the OHSA was amended to include unpaid interns, co-op students, and certain other learners and trainees participating in a work placement program. However, volunteers are not covered by this new definition.
[19] As defined in section 1 (1) of the OHSA, a "competent person" means a person who, a) is qualified because of knowledge, training and experience to organize the work and its performance, b) is familiar with the OHSA and the regulations that apply to the work, c) has knowledge of any potential or actual danger to health or safety in the workplace.
[20] A Joint Health and Safety Committee ("JHSC") is a committee composed of both worker and employer or constructor representatives, jointly committed to improving health and safety conditions in the workplace. The requirements relating to JHSCs are set out in Section 9 of the OSHA.

- If a JHSC is not required and there are more than five workers, the workers must select a Health and Safety Representative.
- Complete a MLITSD Registration of Constructors and Employers Engaged in Construction form.[21]
- Send a Notice of Project to the MLITSD for certain construction projects.[22]
- Develop written emergency procedures and post them on site. Make sure workers and subcontractors know what they are and are following them.
- Ensure ready access to a telephone, two-way radio, or other system of two-way communication in the event of an emergency.
- Report a fatality, critical injury, or other prescribed incident to the MLITSD.[23]

Employer: Many of the general duties of an employer are specified in sections 25 and 26 of the OHSA and additional specific requirements for employers at construction projects are found in Ontario Regulation 213/91 (Construction Projects). Some of the basic general duties and requirements are:

- Provide and maintain all prescribed equipment, materials, and protective devices.
- Ensure that prescribed safety measures and procedures are carried out.
- Instruct, inform, and supervise workers to protect their health and safety.
- Take every precaution reasonable in the circumstances for the protection of workers.
- Prepare and review, at least annually, a written health and safety policy and develop a program to implement it (if the number of regularly employed workers at the workplace is greater than five).
- Appoint a competent person as a supervisor if five or more workers are on the project at the same time.
- Ensure workers have completed training as required by law (e.g., working at heights, Workplace Hazardous Materials Information System ("WHMIS"), etc.).

[21] https://forms.mgcs.gov.on.ca/dataset/016-1000.
[22] The form can be found here: Notice of Project Form #0175 (Revised Ap – Publications Ontario).
[23] Ontario Regulation 420/21 (Notices and Reports Under Sections 51 to 53.1 of the Act - Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents), ss. 3, 4. See subsection 4 (3), para 2. https://www.ontario.ca/laws/regulation/r21420.

- Develop written procedures for rescuing a worker whose fall has been arrested (i.e., a worker hanging by a harness).[24]
- Ensure all workers onsite are at least 16 years of age.[25]

Supervisor: Many of the general duties of a supervisor are specified in section 27 of the OHSA and additional specific requirements for supervisors at construction projects are found in Ontario Regulation 213/91 (Construction Projects). Some of the basic general duties and requirements are:

- Ensure that workers work in the manner and with the protective devices, measures and procedures required by the OHSA and all regulations.
- Ensure that workers use or wear equipment, protective devices, or clothing that is required by the employer.
- Advise workers about actual or potential health and safety hazards.
- Give workers written instructions on the measures and procedures to protect themselves, when required.
- Take every precaution reasonable in the circumstances to protect workers.
- Supervise workers personally or have an assistant, who is a competent person, do so.[26]
- Conduct weekly or more frequent inspections, if necessary, of machinery and equipment at the project.[27]

Worker: Many of the general duties of a worker are specified in section 28 of the OHSA. Key responsibilities include:

- Complying with the health and safety legislation and any associated regulations.
- Refraining from using or operating any equipment or machinery or working in a way that could endanger him or herself or other workers.
- Never removing or making ineffective any protective device required by the regulations or by his or her employer, without providing an adequate temporary protective device.

[24] O. Reg. 213/91, s. 26.1.
[25] O. Reg. 213/91, s. 16.
[26] O. Reg. 213/91, ss. 14 (2) and 15 (2).
[27] O. Reg. 213/91, ss. 14 (3) and 14 (4).

- Selecting worker representatives for the JHSC.
- Reporting any violations of the OHSA or applicable regulations, the absence of or defect in any equipment or protective device, or any workplace hazards to the employer or supervisor.
- Using or wearing the equipment, protective devices, or clothing that is required by the employer.
- Never engaging in horseplay on the job site including pranks, competitions, showing off strength, roughhousing, or unnecessary running.

In addition to general duties outlined in the OHSA, there may be worksite specific rules that workers must follow in the applicable regulations.

Fall Protection

The OHSA and regulations set out requirements on fall protection. Falling is not defined in the OHSA but is understood as the "sudden act of rapidly descending in an uncontrolled manner because of gravity from a higher to a lower level".[28] Section 26 of Ontario Regulation 213/91 (Construction Projects) requires a method of fall protection to be used when a worker is exposed to one of the following hazards:

- Falling from a height of more than 3 metres.
- Falling from a height of 2.4 metres where a worker may be exposed to fall while working on a floor, including a mezzanine, the surface of a bridge, a roof while formwork is in place or a scaffold platform or other work platform, runway or ramp.[29]
- Falling from a height of more than 1.2 metres if the work area is used as a path for a wheelbarrow or similar equipment.
- Falling into operating machinery.
- Falling into water or another liquid.
- Falling into or onto a hazardous substance or object.
- Falling through an opening on a work surface.[30]

[28] https://www.ontario.ca/page/achieve-compliance-construction-sites-fall-prevention.
[29] See Ontario Regulation 213/91, s. 26.3.
[30] https://www.ontario.ca/laws/regulation/910213/v20#BK9.

If workers are exposed to any of these hazards, employers can consider a **hierarchy of controls** to determine how best to protect them. The hierarchy of controls, listed below in order of effectiveness, is a set of actions ranked from most effective and protective to the least effective and protective. They are:

- **Elimination:** Remove the hazard
- **Substitution:** Replace the hazard
- **Engineering Controls:** Isolate workers from the hazard
- **Administrative Controls:** Change the way people work
- **Personal Protective Equipment (PPE):** Protect the worker with PPE[31]

Among the controls, the highest ranked method of fall protection is a guardrail. Subsection 26.1 (1) of Ontario Regulation 213/91 (Construction Projects) mandates that a worker be protected by a guardrail system that meets the specifications laid out in subsection 26.3 (4) of the regulation.

If a guardrail is not feasible or practical, an employer must use the highest ranked method of fall protection that is practicable as outlined in subsection 26.1 (2) of that regulation. These methods include:

- A travel restraint system that meets the requirements of section 26.4.
- A fall restricting system that meets the requirements of section 26.5.
- A fall arrest system, other than a fall restricting system designed for use in wood pole climbing, that meets the requirements of section 26.6.
- A safety net that meets the requirements of section 26.8.

To properly use fall protection equipment, workers must be adequately[32] trained in its use. Ontario Regulation 297/13 (Occupational Health and Safety Awareness and Training), made under the Act, clarifies the working at heights training requirements for workers on a construction project that are required to use any of the following methods of fall protection:

[31] See Workplace exposure and illnesses | ontario.ca. For more information, see the explanation from the Canadian Centre for Occupational Health and Safety at https://www.ccohs.ca/oshanswers/hsprograms/hazard/hierarchy_controls.html.
[32] See subsection 26.2 (1) of Ontario Regulation 213/91.

- Travel restraint system
- Fall restricting system
- Fall arrest system
- Safety net
- Work belt
- Safety belt

Any training program taken by the worker must be:

- Approved by the CPO under subsection 7.1 (2) of the OHSA as meeting the working at heights training program standard that applied at the time of the training.
- Provided by a training provider who has been approved by the CPO under subsection 7.2 (2) of the OHSA as meeting the working at heights training provider standard that applied at the time of the training.[33]
- Completed before a worker is permitted to use fall protection.

Working at heights training is not a one-time requirement and recertification is required periodically. Working at heights training is valid for three years from the date of completion of the training program.[34]

[33] Ontario Regulation 297/13, s. 7 (2).
[34] Ontario Regulation 297/13, s. 8.

Chapter 3: Statistical Overview

Ontario's health and safety system is built on several key pillars:

- **Legislation and Regulation:** The *Occupational Health and Safety Act* ("OHSA") provides the legal framework for workplace health and safety in Ontario. It sets out the duties of owners, constructors, employers, supervisors, workers and others, and establishes procedures for dealing with workplace hazards.
- **Ministry of Labour, Immigration, Training and Skills Development ("MLITSD"):** The MLITSD oversees and coordinates the occupational health and safety system, develops laws, and enforces compliance.
- **Workplace Safety and Insurance Board ("WSIB"):** The WSIB provides wage-loss benefits, medical coverage, and support for workers to return to work. It also funds health and safety programs.
- **Health and Safety Associations ("HSAs"):** Designated entities that support health and safety in Ontario. These organizations provide sector-specific health and safety training and resources, workplace training or occupational disease information and clinical services.
- **Internal Responsibility System ("IRS"):** This system emphasizes that everyone in the workplace has a role to play in maintaining a safe and healthy environment.

Despite significant investment in and commitment to ensuring the safety of Ontario's construction workers and measured improvement in the rate of death among construction workers, deaths resulting from falls continue to occur; falling from heights remains a significant hazard to workers in the sector.

The Data

One hundred and thirty-seven construction workers died after a fall from height between 2009 and 2024. This chapter examines data from investigations by inspectors at the MLITSD and coroners at the OCC into 131 construction deaths that occurred between 2009 and 2024.

Seventy-nine of the 131 deaths have already been examined at an inquest. Collection and analysis of records from both investigations and inquests is still ongoing. As a result, our database, while sizeable, is not yet comprehensive. The

collection and review of these records will continue, and more complete information will be presented in future CDR reports.

The OCC has also identified and expects to review an additional 32 fall-related deaths in one or more future reviews. Some of these deaths are currently under investigation or prosecution by the MLITSD and, to avoid interfering with the MLITSD's processes, these deaths will be deferred to a future review under subsection 10.2 (3) of the *Coroners Act*.

The 26 workers whose deaths occurred between 2017 and 2023, and who are the subject of this review, are included in the 131 deaths. In addition to exploring the trends in the preliminary data for the 131 deaths, this chapter will also specifically focus on the data related to the 26 workers and examine similarities and differences in the trends compared with those found for the 131 deaths. For the 26 deaths, the MLITSD has completed its investigation and, where determined appropriate, prosecution. None of these deaths were the subject of an inquest. The deaths occurred in the following years:

Year of Incident	Inquest	Current Review	Future Review
2009 or earlier	8	0	2[1]
2010	8	0	0
2011	7	0	0
2012	3	0	1
2013	9	0	0
2014	9	0	0
2015	9	0	0
2016	9	0	1
2017	5	1	0
2018	10	3	2
2019	2	5	2
2020	0	4	2
2021	0	7	2
2022	0	4	4
2023	0	2	8
2024	0	0	8
Total	79	26	32

Table 1: Distribution of 26 deaths under review, by year, and deaths to be included in future review

[1] Includes one death from 1998 still unavailable for review.

In this report, we use varying terms to refer to the larger grouping of 131 deaths and the smaller grouping of 26 deaths. For the larger group, we may identify them as the "131 deaths", or the "larger sample". For the 26 deaths, we use "26 deaths" or "smaller sample".

There are two further caveats regarding the data discussed in this chapter. First, while death investigations yield significant information, they have not been conducted with the purpose of informing the CDR process. As we recognize the benefit of a more comprehensive database, the CDR Secretariat is working with the MLITSD, the IHSA and the WSIB to identify and gather information. The Secretariat will continue to build a more comprehensive and accurate database with each successive review. Doing so will inform and enhance analyses in future CDR reports.

Second, given the number of deaths and the complexity of the issues under review, we recognize it is not possible to make definitive statements or to engage in analysis that leads to specific conclusions. The OCC believes that this is the beginning of a longer, collaborative conversation with governmental and sectoral participants. Our hope is that with increased data available from each subsequent review, patterns will become more apparent and potential solutions will become clearer to those with key roles in the sector.

Introduction

Overview – Deaths and Critical Injuries, 2009-2024

Over the past 10 years, deaths in the construction sector have continued to represent a significant portion of Ontario's workplace deaths. Total deaths in the construction, industrial, health care and mining sectors have fluctuated between a low of 39 in 2012 and a high of 65 in 2013 and 2022. Construction deaths constitute approximately 36 percent of these workplace deaths, with 2018 representing the deadliest year proportionally at 48 percent and 2022 the least at 27 percent.[2]

[2] Numbers calculated using MLITSD "Fatalities" data sheet found in Ontario's Open Data Catalogue. Occupational Health and Safety worker fatality and critical injury counts report - Fatalities - Ontario Data Catalogue.

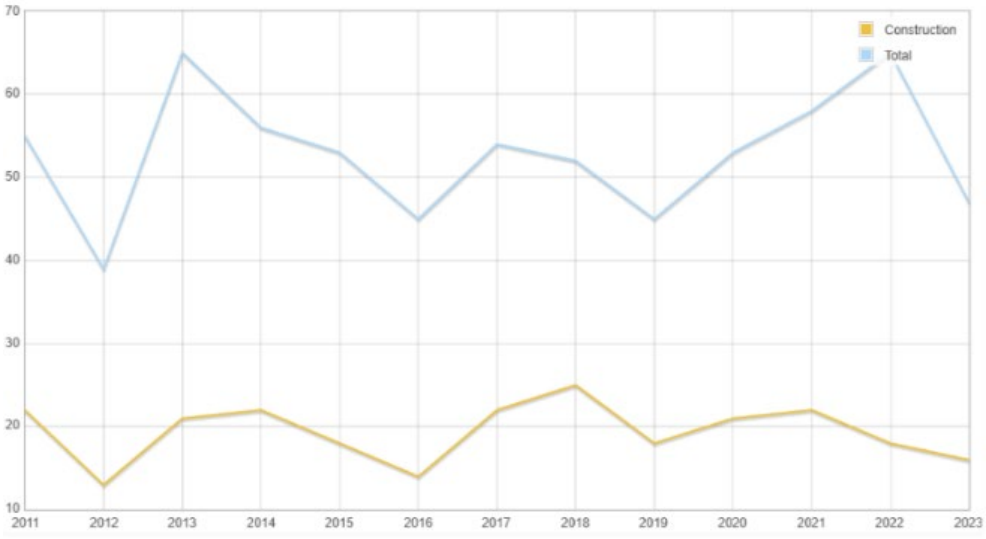

Figure 2: Workplace Deaths vs Construction Deaths

Unlike the fluctuation in workplace deaths, critical workplace injuries have been rising steadily since 2016, from a low in 2015 of 873 across all workplaces to a high of 2,918 in 2023.[3] Critical injuries in the construction sector mirror this pattern, rising from a low of 162 in 2015 to a high of 450 in 2023. Causes for this rise are unknown at this time but it would be important to look at the critical injury rate to determine what role a growing construction workforce plays.

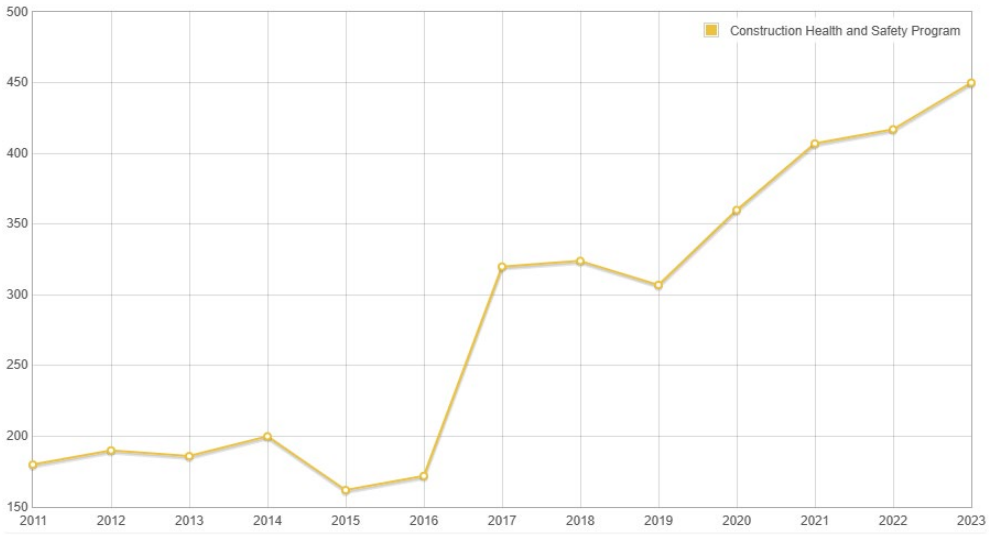

Figure 3: Critical Injuries, 2011-2023

[3] Occupational Health and Safety worker fatality and critical injury counts report - Critical injuries - Ontario Data Catalogue.

Growing Workforce

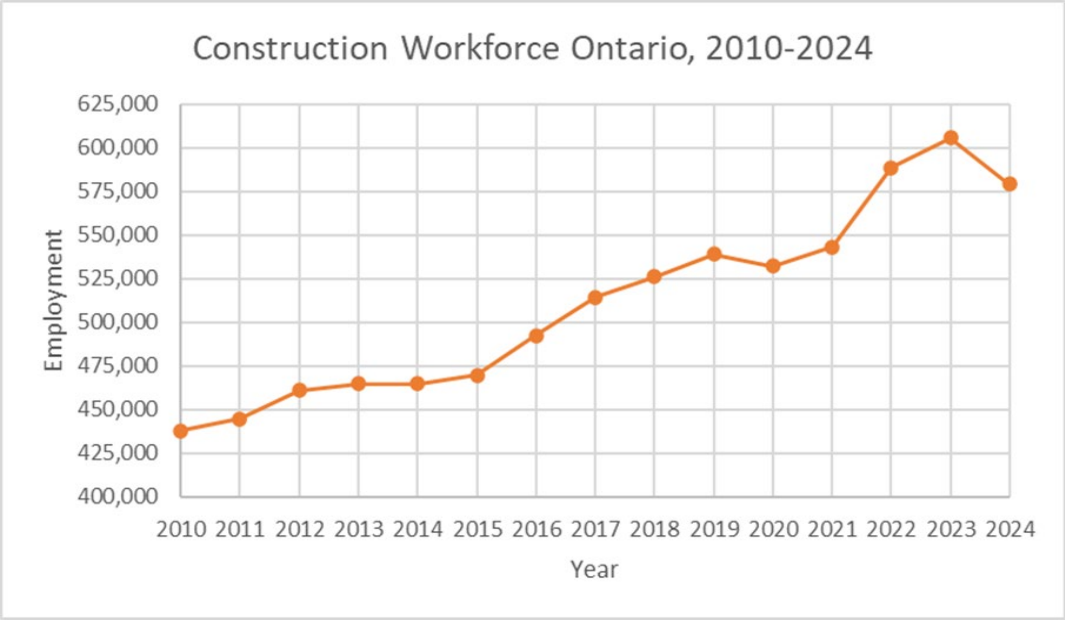

Figure 4: Construction Workforce in Ontario, 2010-2024

The rise in deaths and injuries must be viewed with the context of the increase in the total number of workers in the sector and the number of hours worked. As the graph above illustrates, the construction workforce has risen steadily over the past 15 years. At its peak in 2023, the construction sector employed 605,400 workers, approximately 167,000 more than in 2010, a roughly 40 percent increase.[4]

The number of hours worked also indicates significant growth in the sector. Since 2010, when Ontario's construction workers logged 832,125 hours, working hours have been rising steadily. By 2023, workers had logged 1,228,338 hours.[5] When the growth of the workforce and number of hours worked are considered, the death rate in the sector has reduced noticeably, from about 0.03 deaths per one million work hours in 2010 to 0.0133 deaths per one million work hours in 2023.[6]

[4] Statistics Canada. (2025). Table 14-10-0023-01: Labour Force Characteristics by Industry, Annual. https://doi.org/10.25318/1410002301-eng.
[5] Hours worked, by NAICS industry.
[6] https://www.ihsa.ca/pdfs/lm/MLITSD-Monthly-Construction-Program-Reports/2024/MLITSD-Report-for-LM-Network-04-2024.pdf.

Government Efforts

The provincial government has committed significant resources to training and information sharing, enforcement, and compliance. There has been a strong commitment to have appropriate training measures in place, and both the MLITSD and its stakeholders conduct information campaigns to ensure access to the most up-to-date information. New mandatory working from heights training has had a beneficial effect. After Ontario made working at heights training in the construction sector standardized and mandatory, the rate of fall from height injuries leading to time off work feel by 19 percent.[7]

In addition, approximately 500 MLITSD inspectors conduct thousands of proactive workplace inspections throughout the province each year.[8] These inspections are intended to verify compliance with the OHSA, including but not specific to requirements surrounding working at heights. Inspectors may encourage compliance by providing education and assistance. They may also enforce compliance by issuing orders, or address non-compliance by issuing tickets or by recommending prosecutions under the OHSA, which may lead to fines for corporations or fines and/or imprisonment for individuals.[9] Beyond proactive inspections, MLITSD inspectors also investigate incidents (including both injuries and fatalities), work refusals, and complaints. Similar to proactive inspections, these investigations may result in orders and prosecutions under the OHSA.

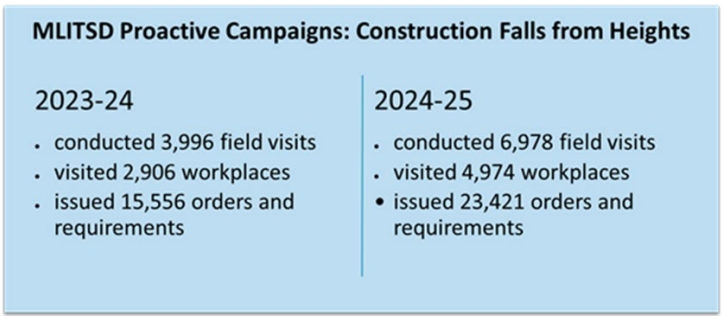

Figure 5: Recent Annual Construction Workplace Visits

[7] IWH, "Worker Injuries due to Falls from Heights declined" at https://www.iwh.on.ca/media-room/news-releases/2023-nov-03.
[8] Roughly 30 percent of inspectors are focused on construction workplaces. Chart provided by MLITSD. See also the dataset on the Open Data Catalog at https://data.ontario.ca/dataset/occupational-health-and-safety-inspections-report/resource/9546aa8b-e1d7-489a-9672-0819eaf5227c.
[9] For an overview of inspections and the definitions of the various types of orders, see https://www.wsps.ca/resource-hub/articles/ministry-inspector-visit.

The MLITSD actively seeks to reduce the number of injuries and deaths through targeted enforcement and information campaigns specifically geared towards preventing fall deaths.[10] Since 2010, the MLITSD has held 20 initiatives and campaigns designed to inform and enforce compliance related to falls from heights hazards at construction projects (See Table 5 in "Appendix A" to this chapter). In addition, during proactive inspections, inspectors review and examine key hazards, such as working at heights. While earlier initiatives were specifically geared towards compliance, later initiatives and campaigns generally had an information phase prior to an active enforcement phase. In the enforcement phase, the MLITSD visited construction projects during a specific time frame (e.g., from one month to one year) and, when required, issued orders, including stop work orders. Though the number of sites visited could be relatively small (roughly 5,000 site visits or about three percent of all of Ontario's workplaces on average annually), the unannounced nature of the visits likely enhanced the impact of the campaign.

The MLITSD's approach to campaigns is complicated by the nature of the industry it seeks to regulate. The construction industry is not monolithic. Rather, it is a unique, complex and multi-faceted environment made up of a number of sub-sectors that focus on specific work and project types, each with their own unique characteristics, challenges, and solutions. Of greatest relevance to this report are the following five: Residential, Single Family; Residential, Apartment or Multi-Family; Industrial; Commercial; and finally, Non-Residential construction. While many of the 20 campaigns over the past 15 years have targeted the industry generally, some have focused on specific sectors, notably the residential home sector, which has been the subject of six specific campaigns (2011-12, 2015-16, 2017-18, 2023-24, 2024-25, 2025-26).

[10] The various initiatives are outlined at Workplace compliance initiatives | ontario.ca.

Sectoral Efforts

Alongside the Ministry, the IHSA has played a pivotal role in advancing fall awareness training over the past 15 years. The organization has developed and delivered multiple educational sessions, initiatives and campaigns that have brought knowledge and awareness to workers in the province. In addition to stand-alone initiatives, in 2018, the IHSA inaugurated its Falls Awareness Week, which includes daily talks, advisories and the release of a fall protection toolkit. A full list of the IHSA's efforts can be found in "Appendix B".

Falls from Height, 2009-2024

Many government and sector organizations have been doing their utmost to curb falls from heights as a source of deaths and injuries. While the overall death rate continues to decrease in construction, a continued focus on the deaths that occur is important. Over the past 15 years fall-related deaths represent approximately 43 percent of all construction deaths. In five of the past 14 years, falls accounted for over half of the total construction-related deaths in the year, and in 2016, falls accounted for 71 percent of the deaths in the sector. This outcome could have been much higher, given the relatively consistent number of critical injuries that occur from falls from heights. These data, shown in Table 2, demonstrate that falls represent a diminishing proportion of injuries in the sector.

Ontario Falls from Heights						
Year	**Deaths (falls from heights)[11]**	**Deaths (construction total)[12]**	**Falls deaths as a % of construction total**	**Critical Injuries (falls from heights)[13]**	**Critical Injuries (construction total)[14]**	**Falls Injuries as % of construction total %**
2009	9	17	52	*[15]	*	*
2010	8	24	33	86	*	*
2011	7	22	32	95	180	52
2012	4	13	31	91	190	47
2013	9	21	42	121	186	65
2014	9	22	41	122	200	61
2015	9	18	50	110	162	67
2016	10	14	71	104	172	60
2017	6	22	27	102	320	31
2018	14	25	56	134	324	41
2019	9	18	50	93	307	30
2020	6	21	28	102	360	28
2021	9	22	41	94	407	23
2022	8	18	44	86	417	20
2023	10	16	62	97	450	21

Table 2: Deaths and Critical Injuries in the Construction Sector

It is notable that the number of fall-related deaths and injuries have been consistent over the long term. Since 2010, an average of eight workers have died annually from a fall on a construction project. Two years noticeably deviate from the average: 2012, when four workers died; and 2018, when 14 workers died from a fall from heights.

[11] Based on the 137 deaths known by the Office of the Chief Coroner to have occurred in this time period that would have been referred to a mandatory inquest or to mandatory review.
[12] Occupational Health and Safety worker fatality and critical injury counts report - Fatalities - Ontario Data Catalogue.
[13] Thanks to the IHSA who provided the numbers in this column.
[14] Occupational Health and Safety worker fatality and critical injury counts report - Critical injuries - Ontario Data Catalogue.
[15] Asterisks denote no information available at the time of drafting.

There may be compelling underlying reasons to explain deviations from the norm in these outlier years, but it is not easy to determine causality. Many factors could impact the outcome of an injury, including a change in circumstance at the scene of the incident or a difference in timing of emergency response. We encourage further review of these years to gain further insight to inform better outcomes.

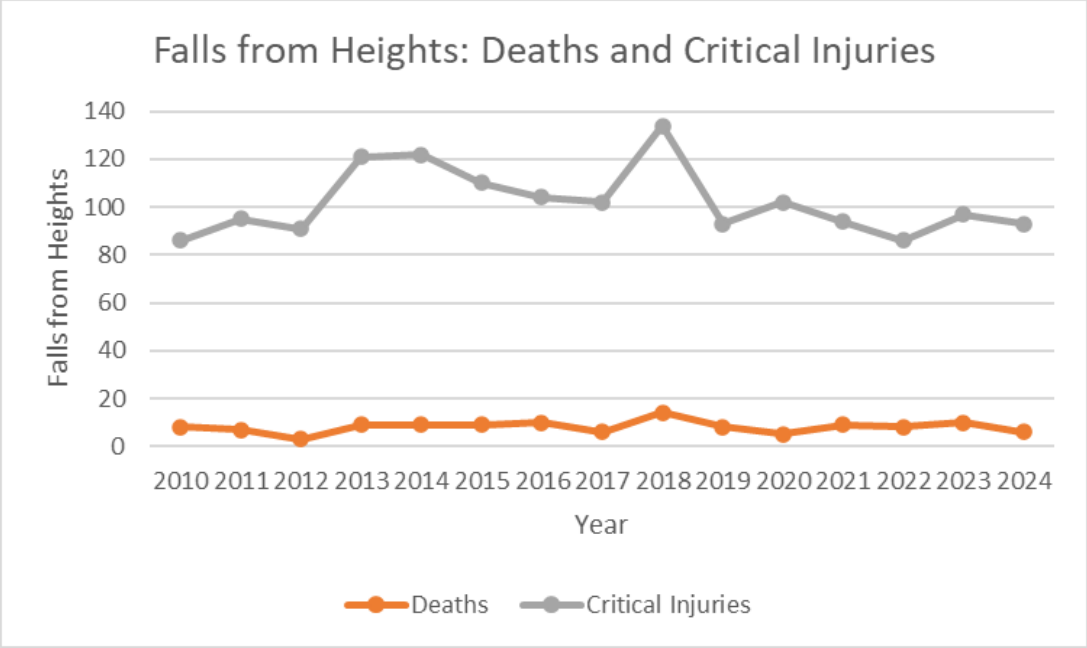

Figure 6: Deaths and Critical Injuries Over Time

Given the change in the size of the workforce and the number of hours worked, we view the number of deaths in construction over time, as shown in Figure 6, to demonstrate that the rate has decreased. However, the consistency in the number of deaths is tragic in that the number of annual deaths is rarely below the average and never hits zero. Improvement in the overall death rate in the construction industry appears to be attributable to workforce expansion (i.e., the number of deaths remains consistent as the industry grows) and not in the decline in the number of workers dying.

The Issues

Demographics – Identifying those who fell

Sex[16]

The construction workforce is overwhelmingly male. Males accounted for 87 percent of the construction workforce in 2023.[17]

Given the disproportionate number of men in the construction workforce, it is not surprising that the vast majority of the deaths in the sector since 2009 were men. Of the 131 total deaths examined, two women died as a result of an accidental fall on a construction project between 2009 and 2024. One of these two deaths was included in the 26 deaths under review in this report.

During this time period, deaths among female construction workers are underrepresented when compared to the total number of women in the sector.

It should be noted that more women are entering the construction workforce, and women's representation in the sector has grown to approximately 13 percent.[18]

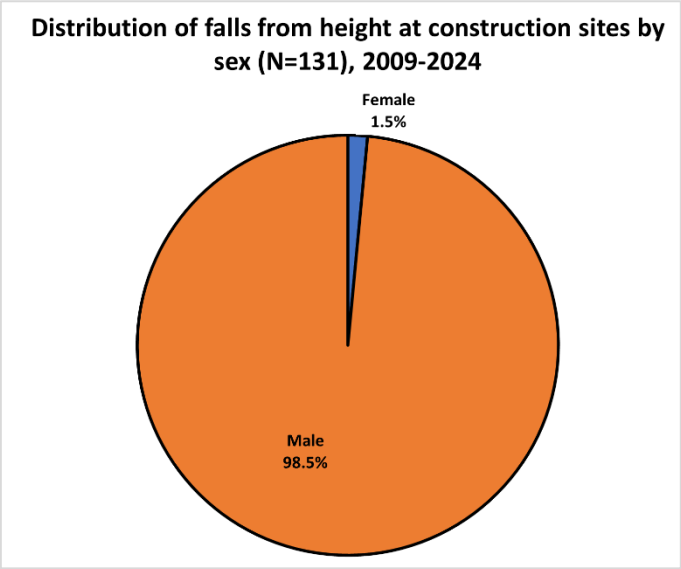

Figure 7: Distribution by Sex, 2009-2024

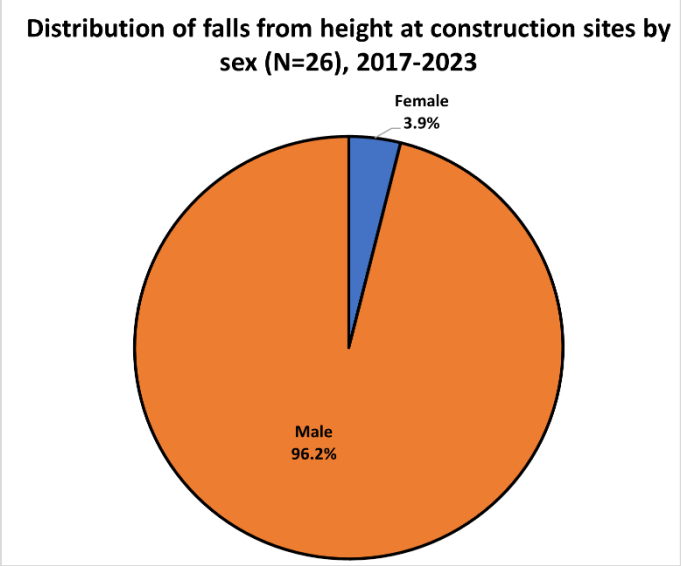

Figure 8: Distribution by Sex, 2017-2023

[16] "Sex" refers to the worker's sex assigned at birth.
[17] https://www.jobbank.gc.ca/trend-analysis/job-market-reports/ontario/sectoral-profile-construction.
[18] The Daily Commercial News reported that the number of women employed in construction had increased over a 12-month period from 194,300 in May 2022 to 221,900 in May 2023. See "Early 2023

It remains to be seen whether this increase will impact the data on deaths according to sex.

Age

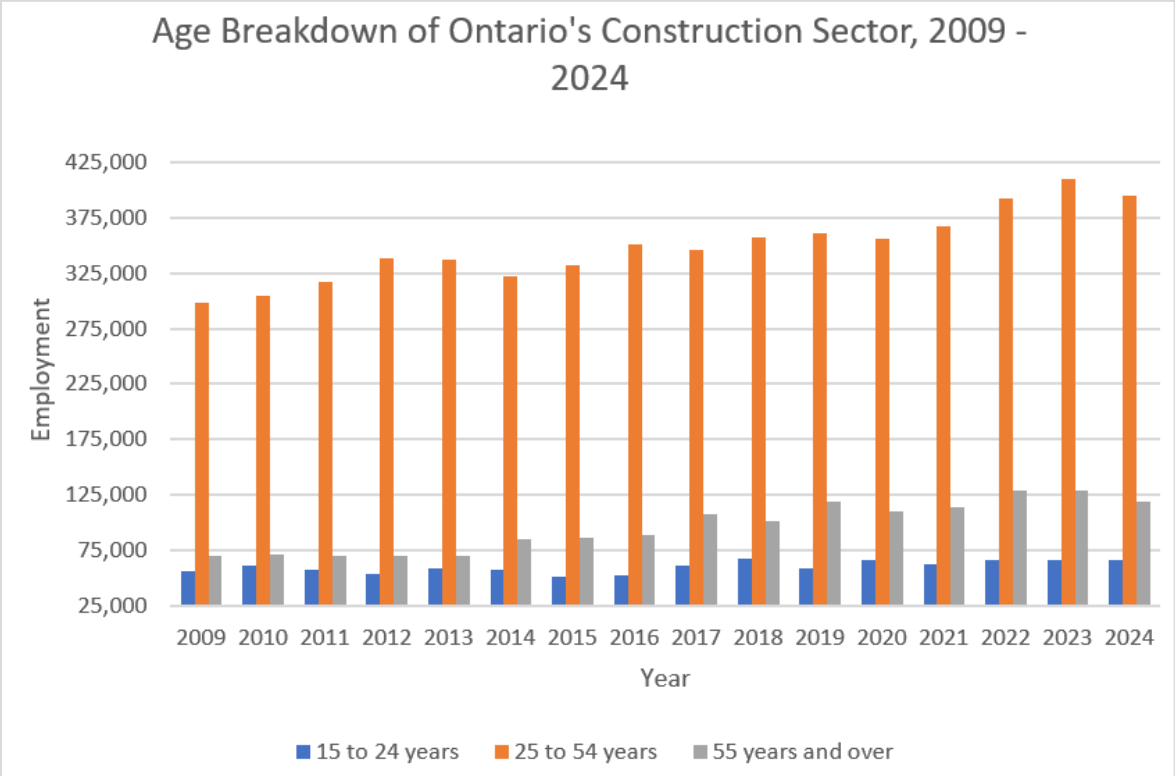

Figure 9: Age Distribution in the Construction Sector

The sector is heavily populated with workers within the 25-54 age bracket. Over the period under review, this worker age bracket has averaged close to 70 percent of the working population, only dropping slightly to 68 percent in recent years. During this same time period, the 15-24 cohort have averaged just over 11 percent of the total population and those aged 55 and over have averaged approximately 19 percent of the total population, rising to 21 percent over the past five years.

Workforce Stats for Women Look Strong," *Daily Commercial News*, August 12, 2023, at https://canada.constructconnect.com/dcn/news/labour/2023/08/early-2023-workforce-stats-for-women-look-strong. See also "Demographics and Diversity: A Portrait of Ontario's Unionized Construction Industry", p.7 at https://iciconstruction.com/wp-content/uploads/2019/11/Demographics-Diversity-Report.pdf.

Given that most construction workers are aged 25-54, it is not surprising that most of the 131 deaths were of workers from this age bracket. Proportionally, however, those 25-54 suffered fewer deaths than would be expected and the age group is slightly underrepresented among all deceased workers.

As Figure 10 shows, though the 25-54 age bracket represents just under 70 percent of the total workforce, it accounted for just under 60 percent of all deaths between 2009 and 2024. Conversely, workers over the age of 55 are overrepresented among those who died.[19] Though older workers represent under 20 percent of the construction population, they account for 35 percent of the deaths in the sample of 131 deaths.

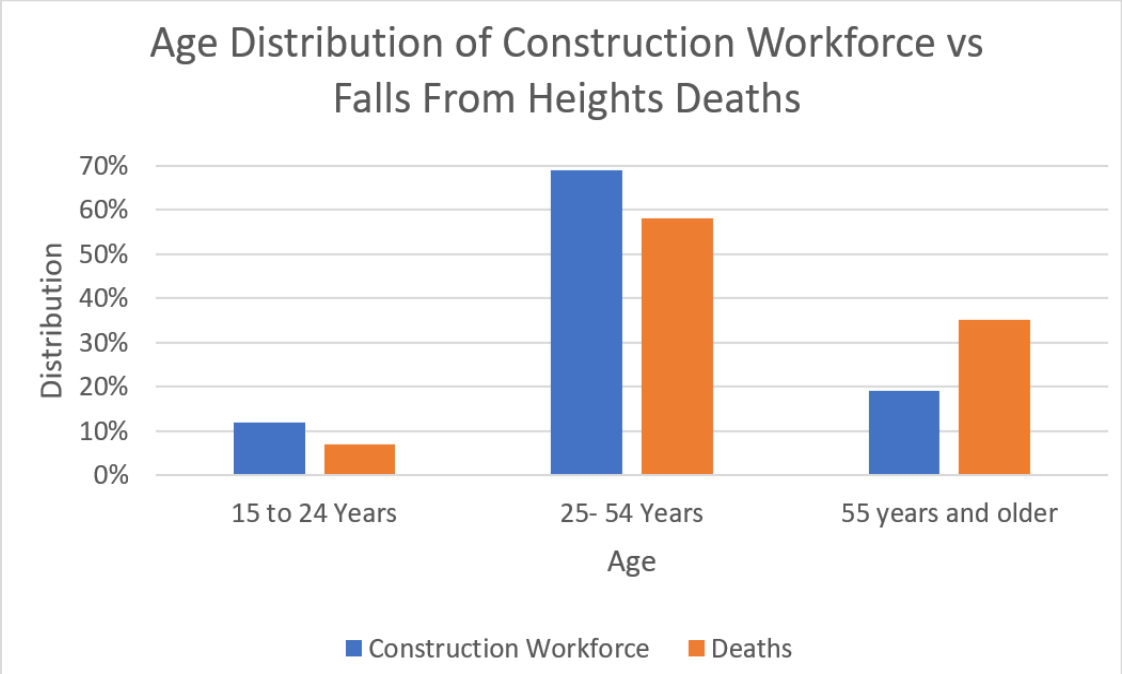

Figure 10: Age distribution, Deaths 2009-2024

Figure 11 breaks down the data further, showing that the workers who died were more likely to be over 40 than under 40. Sixty-seven percent of deaths in the larger sample were over 40. Almost half of those who died between 2009 and 2024 were over the age of 50 and 22 percent were over the age of 60.

[19] Statistics Canada. Table 14-10-0023-01. Labour force characteristics by industry, annual (x 1,000). https://doi.org/10.25318/1410002301-eng.

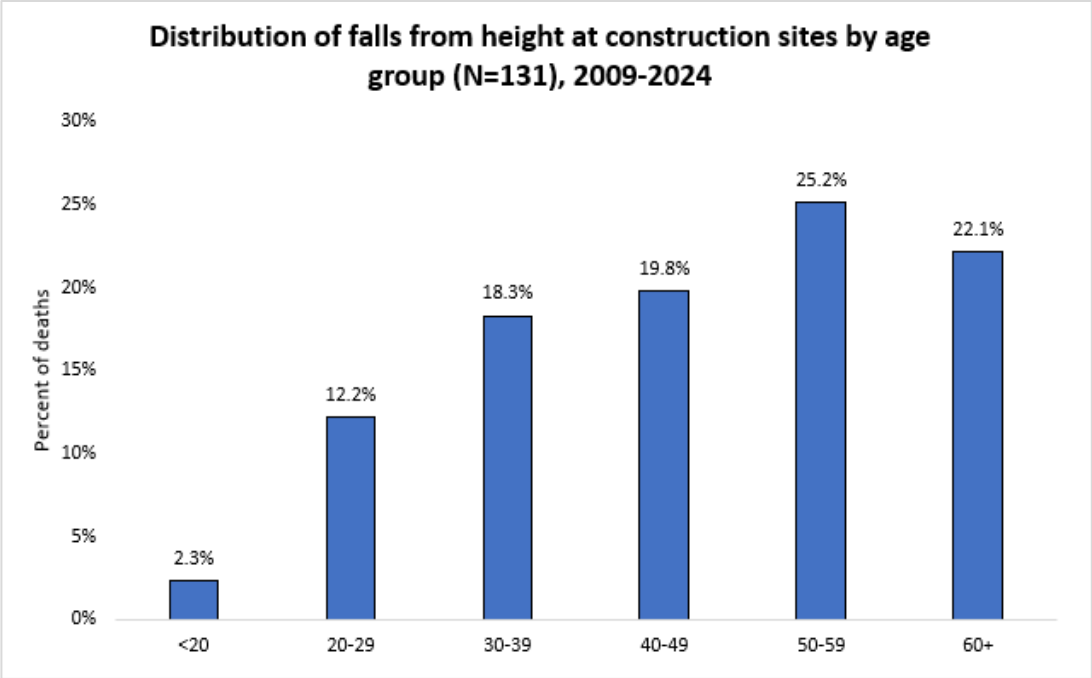

Figure 11: Distribution of Falls by Age, 2009-2024

A similar distribution holds true for the 26 deaths under review in this report. Figure 12 shows that workers over the age of 40 represent almost 69 percent of those who died, and workers over 60 represent almost 27 percent of the deaths.

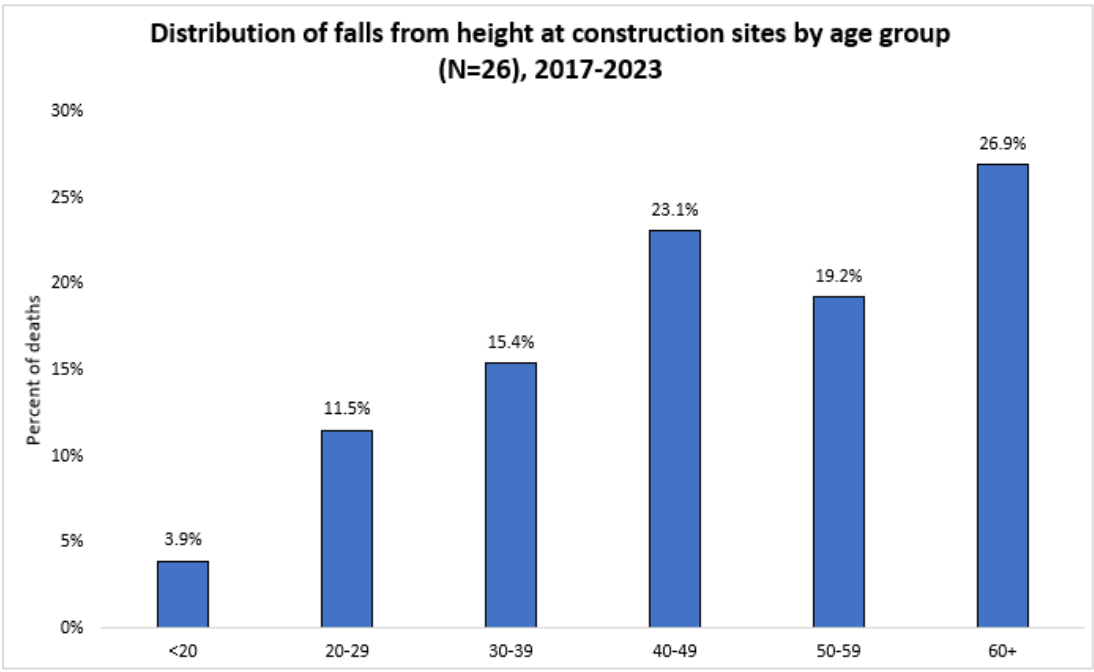

Figure 12: Distribution by Age, 2017-2023

Age at death also appears to be correlated with the height of the fall, though without knowing the number of opportunities workers in each age group have to work at different heights, conclusions cannot be made. Figure 13 shows the distribution of the heights from which 118 workers fell. Falls lower than 10 feet were involved in just under 17 percent of the deaths.

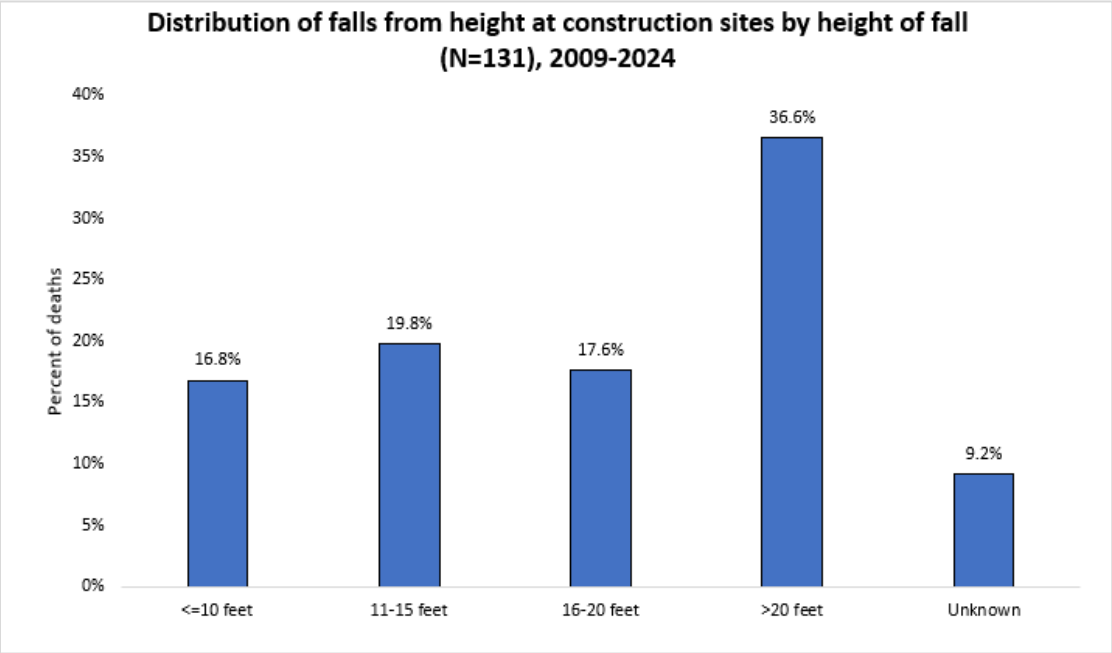

Figure 13: Height of Fall, 2009-2024

Figure 14 shows the age distribution of those who died at different heights. Sixteen percent of workers in their fifties died from a fall of under 10 feet, while 46 percent of those aged 60 and above died from a fall under 10 feet. Fifty-five percent of workers aged 50 to 59 died from a fall between 11 and 19 feet. Workers under 40 were less likely to have died from a fall under 10 feet, with those aged 20-29 dying from this distance just over six percent of the time. Sixty-seven percent of those under age 20 died from a fall from higher than 20 feet, with 33 percent dying after falling between 11 and 19 feet.

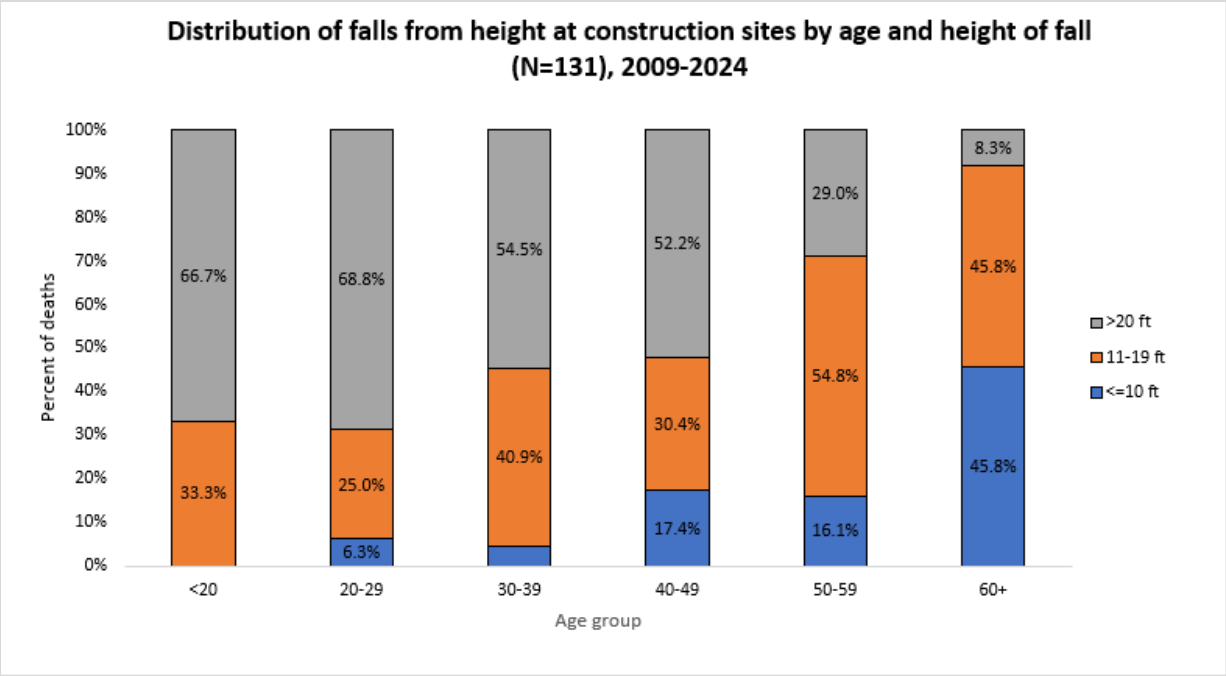

Figure 14: Correlation of Age and Height

Fall heights for the deaths reviewed in this report, are fairly evenly distributed, as demonstrated in Figure 15.

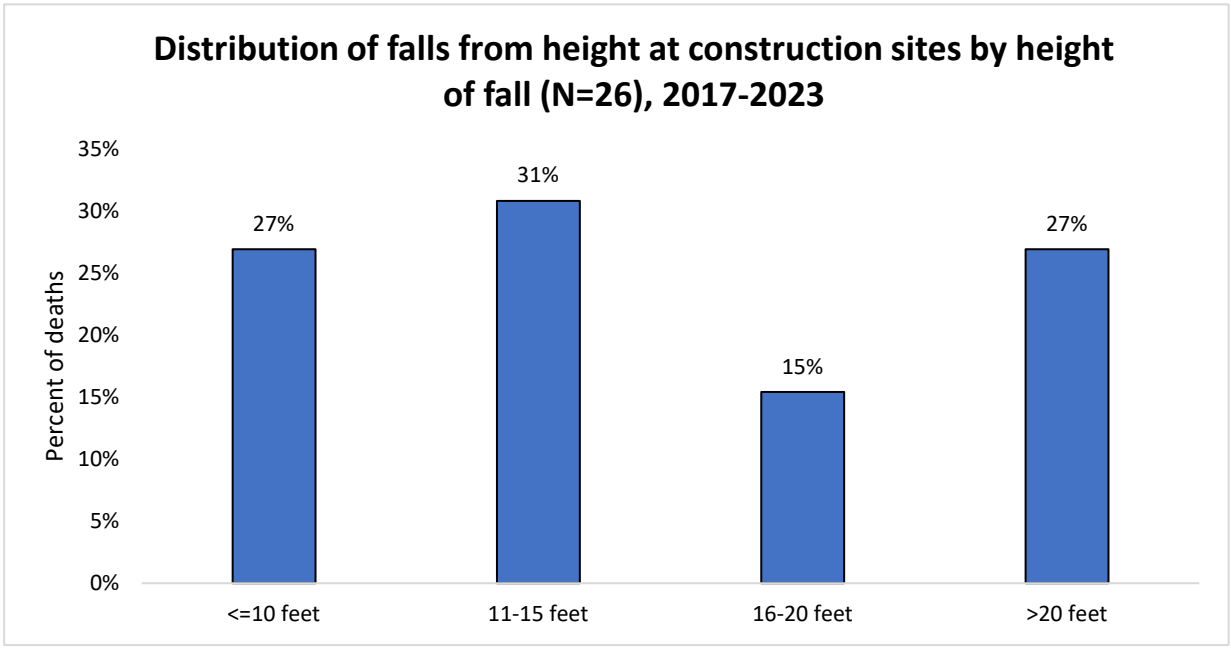

Figure 15: Distribution by height of fall, 2017-2023

Figure 16, however, shows that deaths of workers under the age of 30 were all from heights greater than 20 feet. Most deaths from falls under 10 feet were experienced by those over age 40. More than 85 percent of the deaths from falls under 10 feet were experienced by those aged 60 and over.

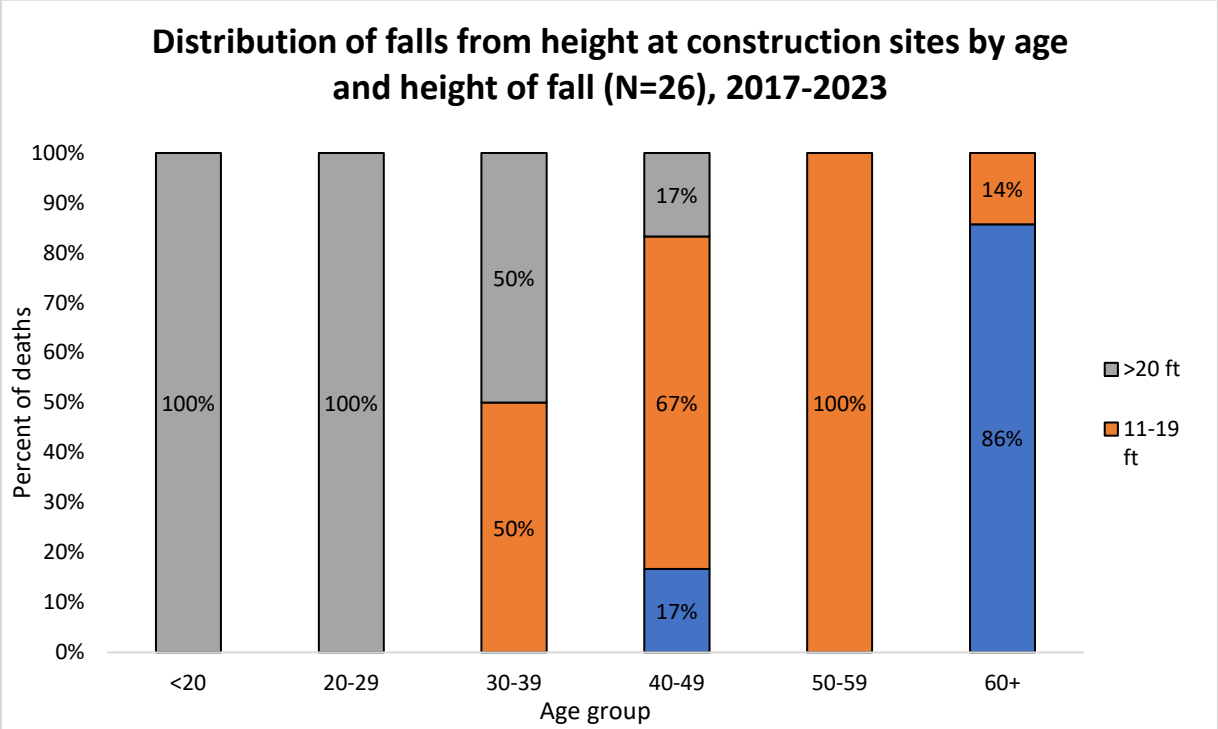

Figure 16: Distribution by Age and Height, 2017-2023

Experience

Other characteristics of the workers we examined were experience in the industry and time served in the positions held just prior to death. We continue to access data to allow assessment of the broader cohort, but initial analysis shows a significant number of workers with little experience in the job that they were performing. Twenty-six of the larger sample had been in their position for less than one year before the incident and four of the smaller sample had been in the construction sector for less than one year. Four workers of the 131 workers had started the day of the incident, i.e., they had no longer than a few hours on the job. Of these 26 workers (from the larger sample), just over half (14) were older than 40 and six of them were over 60.

Among the 26 deaths under review, 13 of the workers had been in their positions less than one year and three had started working that day. Four had been in the industry for less than one year and two had no prior experience in the construction industry. One had just purchased their first pair of construction boots on the morning they started.

Lack of experience is not correlated with age. Seven of the workers among the 13 workers who had been in their positions less than 1 year were over age 40 and four were over age 60.

Location of Fall

In reviewing the deaths, we found that workers can fall many different ways on a construction project, with the most common locations listed in Figure 17. The "other" category includes falls from staircases, through holes in the ground, down elevator shafts or from heights achieved via mechanical means, including bucket trucks. While there are a number of different platforms from which to fall, the majority died falling from one of three locations: roofs, ladders and scaffolds.

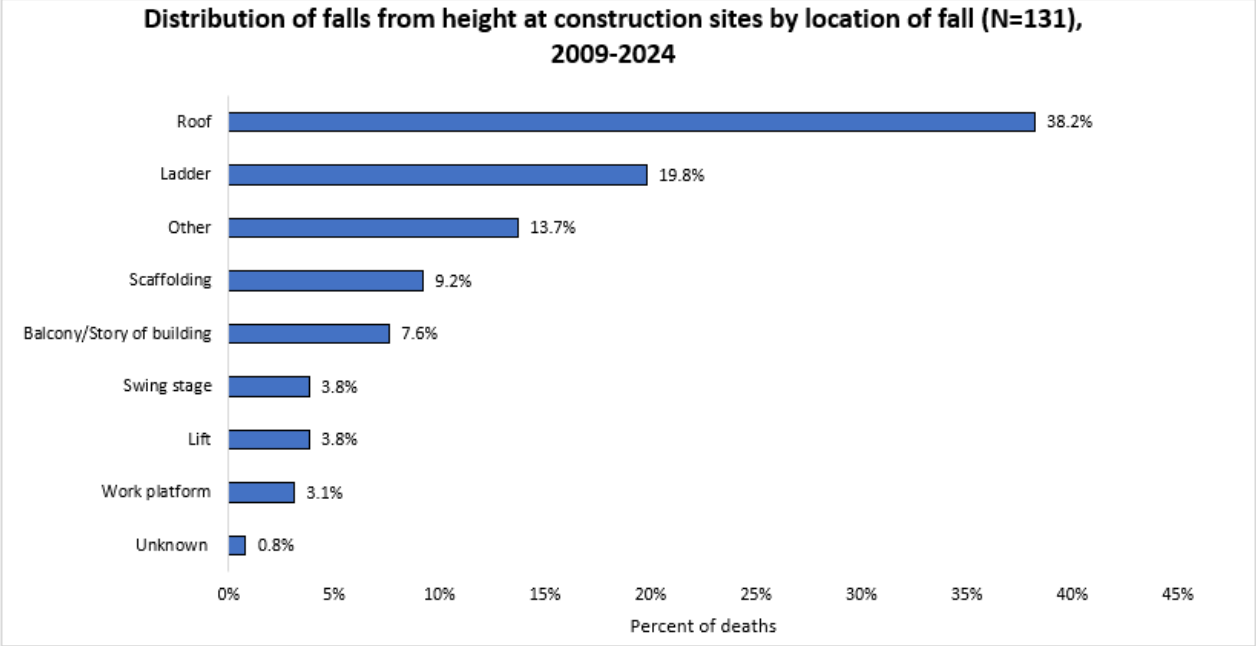

Figure 17: Location of Fall, 2009-2024

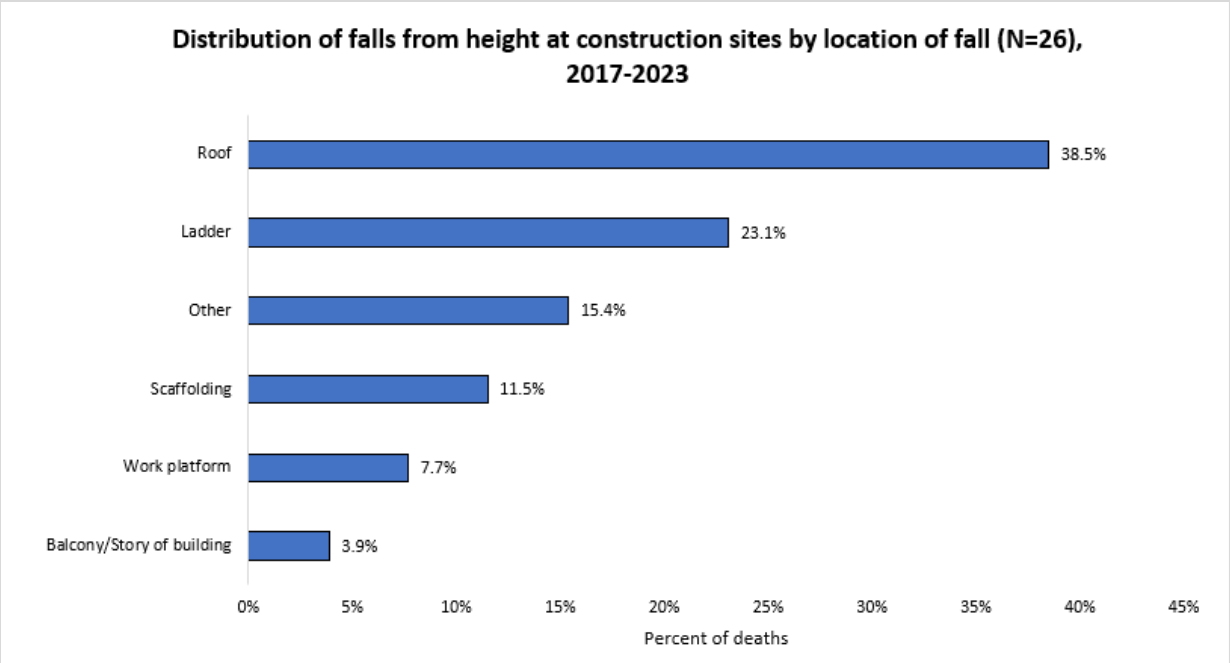

Figure 18: Location of Fall, 2017-2023

A similar pattern is present in the 26 deaths under review. Roofs, ladders and scaffolds are the most common locations from which fatal falls occurred.

Roofs

Fifty workers, representing nearly 40 percent of all falls, died while working on a roof.

Roofs varied in height, with 12 deaths resulting from a fall between 11 and 15 feet, 10 deaths resulting from a fall between 16 and 20 feet, and 20 falls from higher than 20 feet.

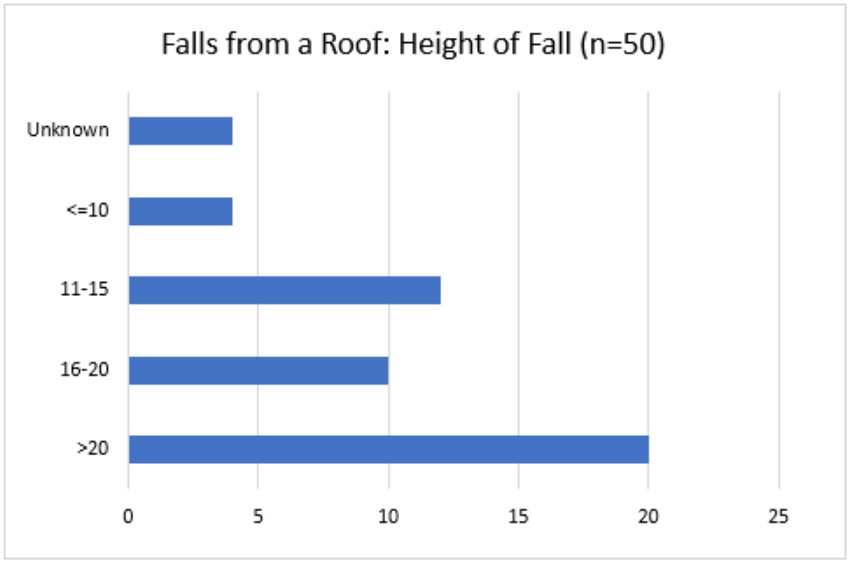

Figure 19: Falls from a Roof, 2009-2024

For 10 of the 26 workers under review in this report who fell from a roof, eight occurred from 11 feet or higher, with four from higher than 20 feet. The two falls under 10 feet occurred from a height of less than three metres (nine feet, 10 inches), where the use of fall protection equipment would not have been required.

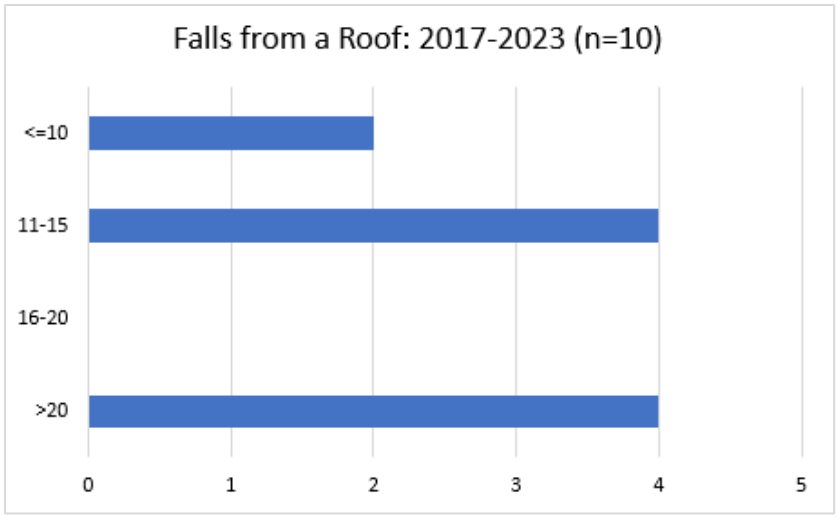

Figure 20: Height of Fall from Roof, 2017-2023

Ladders

Twenty-six of the 131 workers fell from ladders, nine from a height of under 10 feet, eight from 11 to 20 feet, and six from over 20 feet. Of the nine falls under 10 feet, only two occurred from a height of more than three metres (nine feet, 10 inches), where the use of fall protection equipment would have been required. The other seven falls were from heights less than three metres.

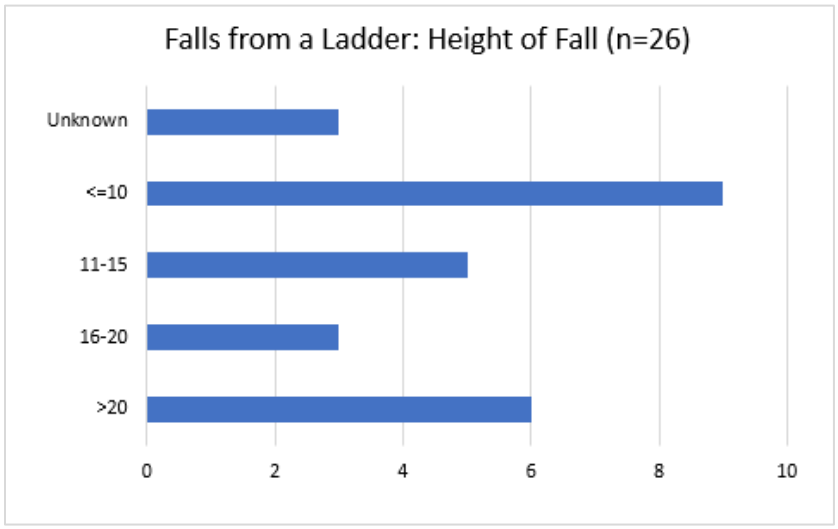

Figure 21: Height of Fall from Ladder, 2009-2024

Of the 26 workers under review in this report, six workers died after a fall from a ladder. Of the six deaths, three were from a height under 10 feet, and one death each resulted from a fall from 11-15 feet, 16-20 feet and over 20 feet, respectively. Of the six falls under 10 feet, five occurred from a height less than the three-metre height where the use of fall protection would have been required.

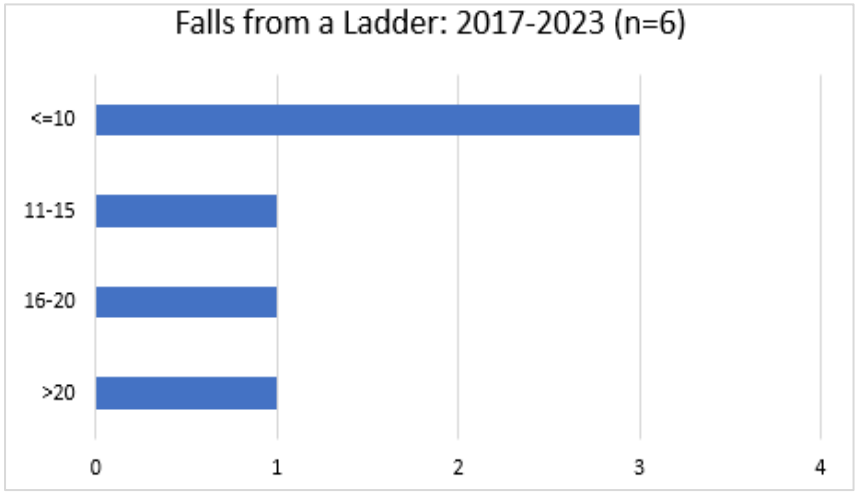

Figure 22: Height of Fall from Ladder, 2017-2023

Use of Fall Protection Equipment

As noted in Chapter 2, the requirements relating to use of fall protection equipment while working at heights are very specific. There are a few considerations for the data in this section. First, objective observers have recognized significant uptake of working at heights training. That said, not every worker may have anticipated needing the training, particularly where the workers were not expected to be working at heights. Similarly, not all of the circumstances under review required that the worker who died use fall protection equipment. For example, those who were working at a height less than three metres would not be required to use fall protection, depending on the circumstances of their task.

Of the 131 worker deaths, we identified 17 individuals who may have been working at heights of 10 feet or under. Of those 17 individuals, six were identified as likely working at heights around 10 feet, and 12 as likely working at heights under nine feet. Under the current three metre (nine feet, 10 inches) threshold, only those 12 individuals would not have been required to use fall protection. There are still gaps in our database regarding the use of fall protection by all 131 deceased workers,

specifically those who died between 2009 and 2015. We are working with the MLITSD and others to obtain this information.

The charts in this section show the distribution of falls by fall protection equipment status, but the results are restricted to those who were exposed to a hazard over three metres.

Figure 23 shows that approximately 54 percent of the 131 workers who died from falls from heights between 2009 and 2024 who met requirement to be using fall protection equipment were not using it. As the number of unknowns in the larger sample reduces based on additional data received from the MLITSD and others, the distribution will likely change.

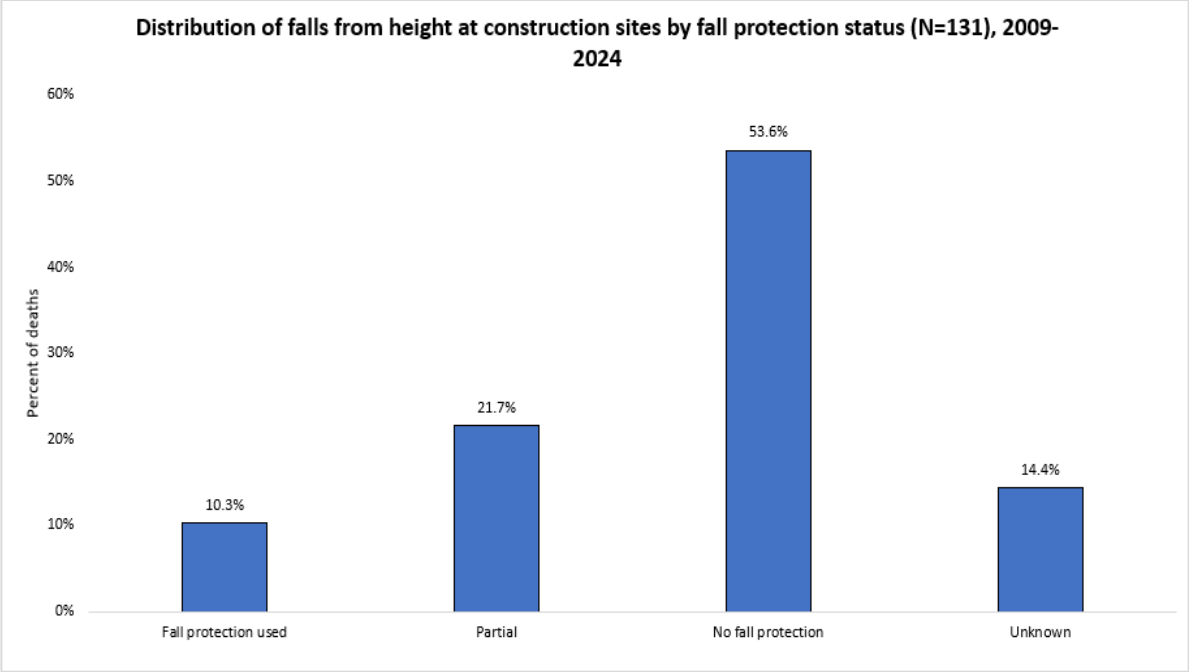

Figure 23: Fall protection equipment status, 2009-2024

A similar story emerges when evaluating the fall protection equipment status of the 26 workers in this review, for whom there is a more complete data record. These numbers are derived from a review of the deaths where the worker was exposed to a hazard over three metres in height. Among these workers, almost 77 percent had received working at heights training.

It is, therefore, surprising that 63 percent were exposed to a hazard and were not protected by fall protection equipment or were using it improperly. Only 16 percent were using the appropriate fall protection equipment to protect them in their work circumstances.

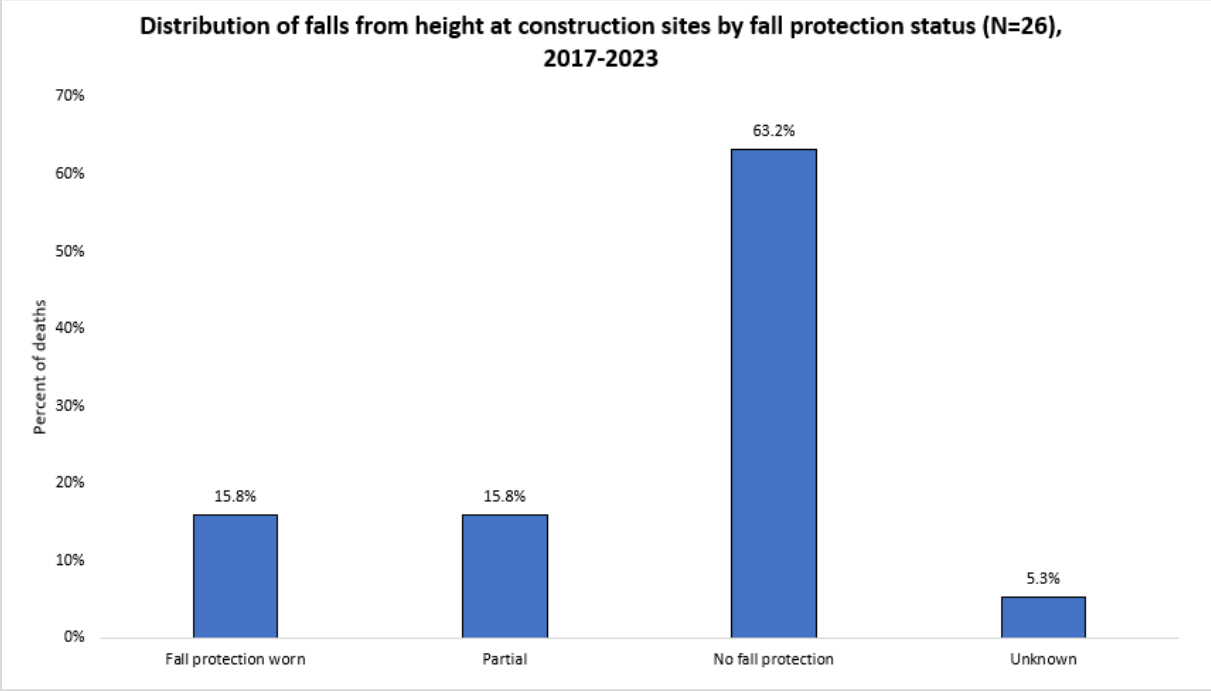

Figure 24: Fall protection equipment status, 2017-2023

Some of the individuals who died may have had no training in working at heights or were not using fall protection because they were not expected to be working at heights. The number of individuals not using fall protection required under Ontario Regulation 213/91 (Construction Projects) suggests a broader issue that will likely benefit from further analysis over time.

Size of the Company

One of the larger gaps in the data that the CDR Secretariat has collected relates to the size of the companies employing the workers at the time of their deaths. We have little detail relating to 55 percent of the companies for which those who died worked.

Table 3 outlines the size of 55 of the 127 companies that employed the 131 workers, and includes all 26 companies who employed the workers under review:

Company Size (Employees)	Total Number (n=127)	Distribution (%)	Number in 2025 Report (n=26)	Distribution (%)
Owner operator	12	9.3	3	11.5
2-10	36	28.1	13	50
15+	7	5.4	4	15.3
Unknown	72	56.3	6	23

Table 3: Size of company

The number of unknowns in the larger sample limits conclusive analysis; however, the breakdown shows that issues with health and safety may be greater in small and sole proprietor companies, suggesting that continued focus on that part of the sector may be beneficial.

Sub-Sector

As noted, the construction industry is complex and is made up of multiple sub-sectors, each focusing on specific work and project types. We were able to classify the sub-sector of all but 14 of the companies involved in the larger sample and all of the companies in the smaller sample. Table 4 shows the breakdown and distribution of the companies throughout the industry:

Sub-Sector	Total Deaths	Distribution (%)	Deaths in 2025 Report	Distribution (%)
Residential, Single Family	44	34	14	53
Residential, Multi-Family/Apartment	26	20	2	7
Commercial	17	13	6	23
Industrial	12	9	1	3
Other non-residential	17	13	3	11
Mixed Commercial/ Residential	1	1	0	
Unknown	14	11	0	

Table 4: Deaths in key sub-sectors

Given the varied tasks involved in the building of single-family homes and the number of different contractors and sub-contractors involved, including owner operator and small businesses, the prevalence of worker deaths in the residential home building sector may not be surprising.

Unionization

Unionization in the construction industry across Canada averaged 31 percent between 2020-2024.[20] In Ontario, the average unionization across all sectors was approximately 26-27 percent.[21]

There is not sufficient data to conclusively determine the union status of all 131 workers. There were 29 workers where union status was available. Twenty-four percent were unionized (See Figure 25).

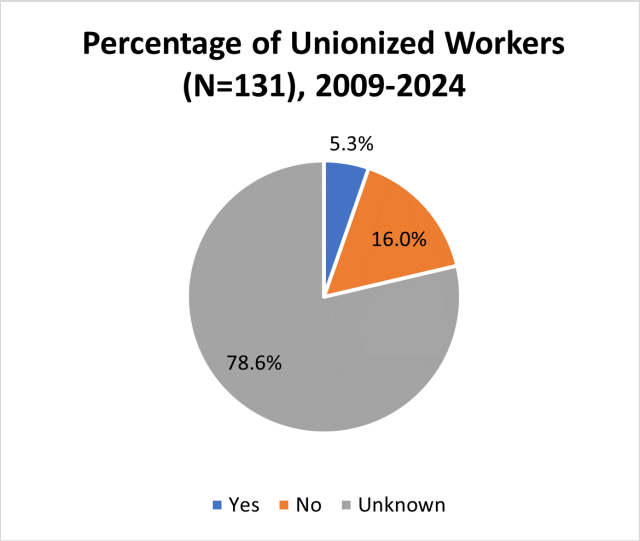

Figure 25: Unionization, 2009-2024

Given the significant percentage of unknowns, more data is required to evaluate for a pattern. We encourage examination of this data point.

We have more complete data for the 26 workers whose deaths were included in the review. Among those workers, four workers were part of a union and 16 were not (See Figure 26). Again, more complete data would allow us to better analyze this data point.

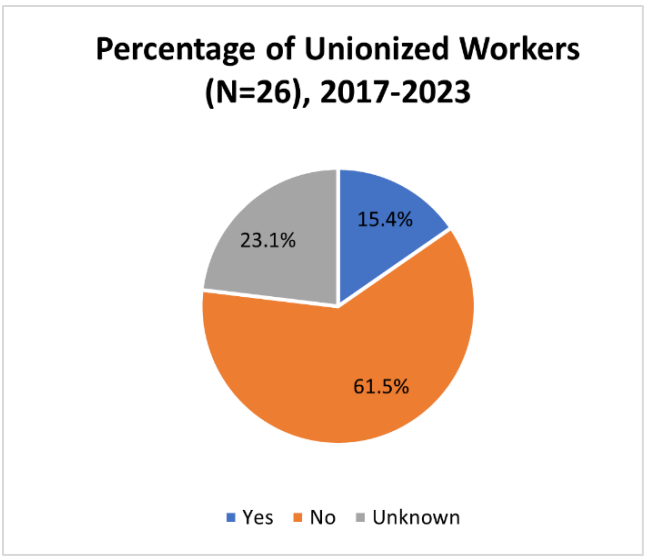

Figure 26: Unionization, 2017-2023

It cannot be determined if membership in a union influences the workplace environment in a way that prevents falls. Given the union's primary role to protect its membership, union participation may add an additional layer to the IRS that ultimately enhances health and safety compliance.

[20] Union status by industry.
[21] Union status by geography.

The impact of unionization is one of the subjects that the MLITSD and other sectoral partners may wish to consider in their future health and safety analyses.

Time of Fall – A Seasonal Issue?

Though an increase in falls during the peak of the summer construction season may be expected, the deaths of the 131 workers examined over the period between 2009 and 2024 do not demonstrate a specifically seasonal pattern.

Figure 27 displays the distribution of the 131 falls throughout the year. While approximately 34 percent of falls over the period between 2009 to 2024 occurred between May and August, when the number of workers in the sector is greatest, approximately 57 percent of falls over the past 15 years have occurred between October and March. This suggests that falls while working at heights is not specifically related to a season or changes in the number of total construction workers employed.

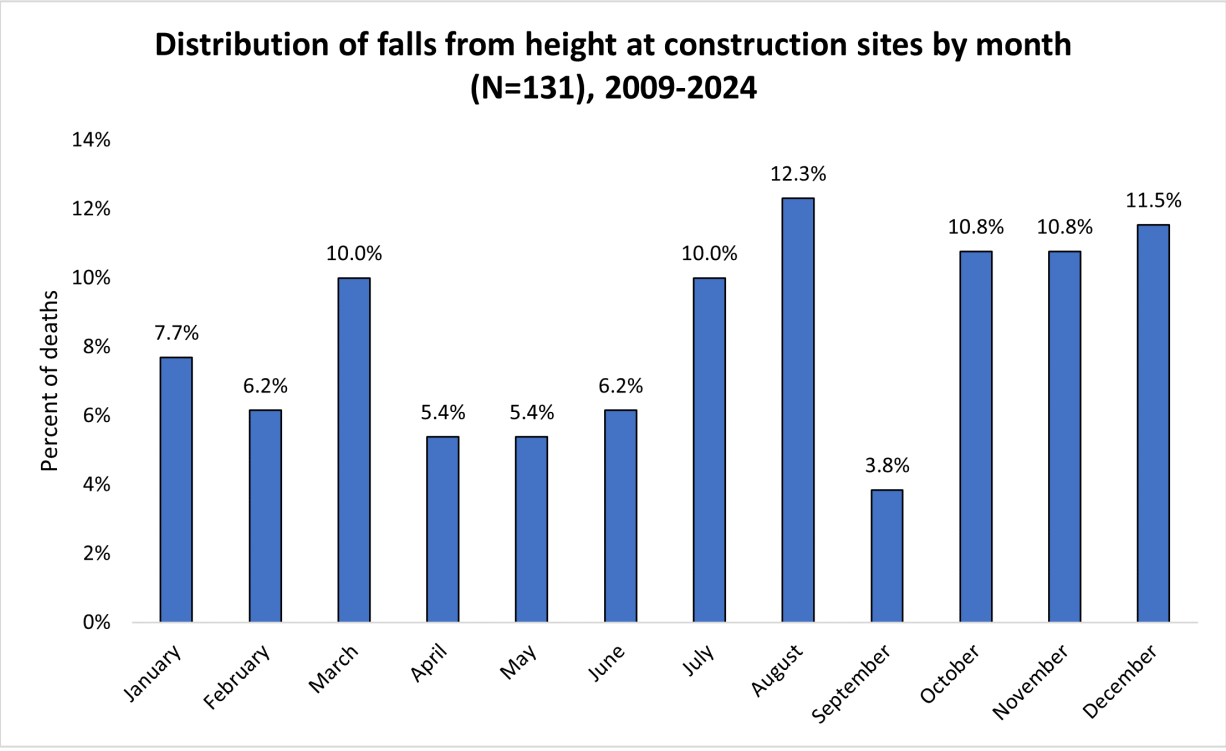

Figure 27: Falls by month, 2009-2024

As demonstrated in Figure 28, the falls of the 26 workers under review occurred along a more seasonal pattern than observed with the larger sample of 131 deaths.

Approximately 50 percent of the 26 falls occurred between March and August. When compared with the broader group, January, April, and October were significantly more represented for the 26 workers under review than for the workers in the larger group.

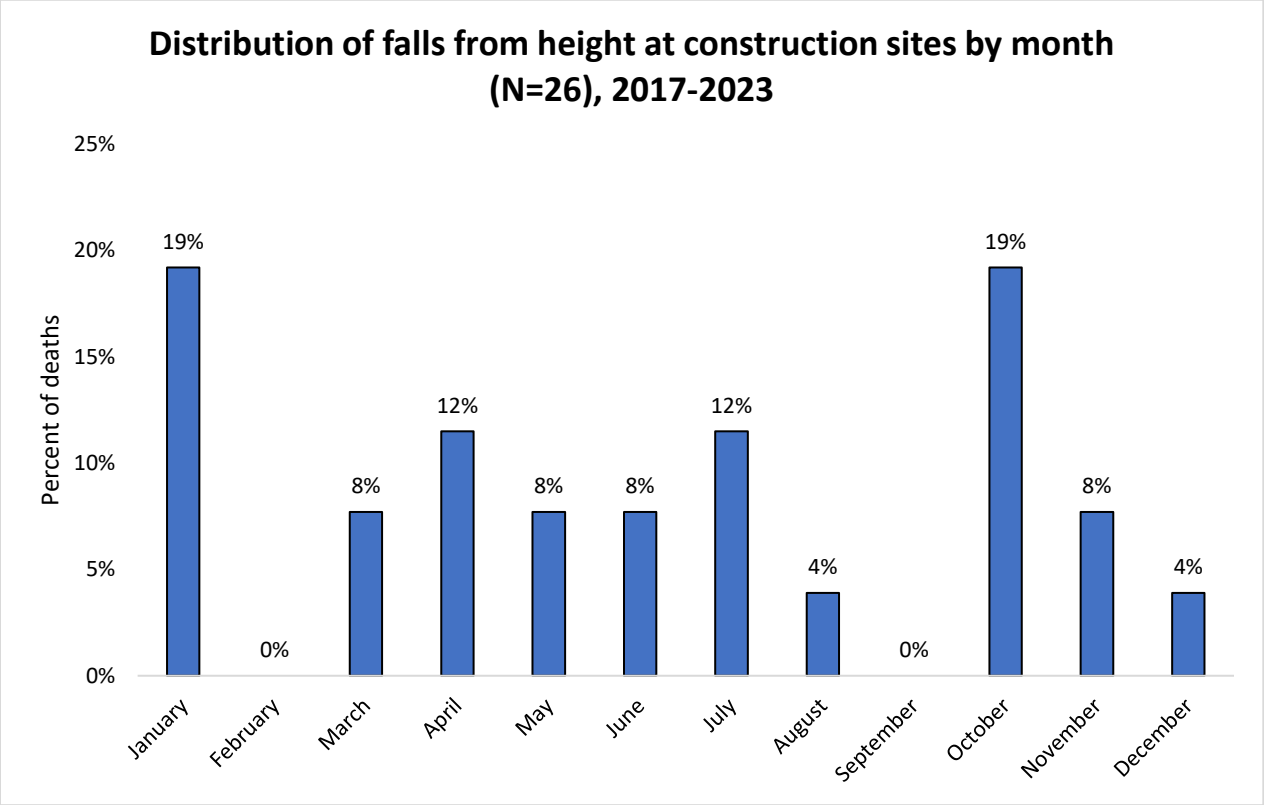

Figure 28: Falls by month, 2017-2023

Time of Fall – A Weekend Issue?

A pattern emerged when we reviewed falls by day of the week. In our sample of 131 deaths, just over 54 percent of falls occurred between Thursday and Sunday. Friday was the most significant day, with almost one-quarter of falls occurring on a Friday.

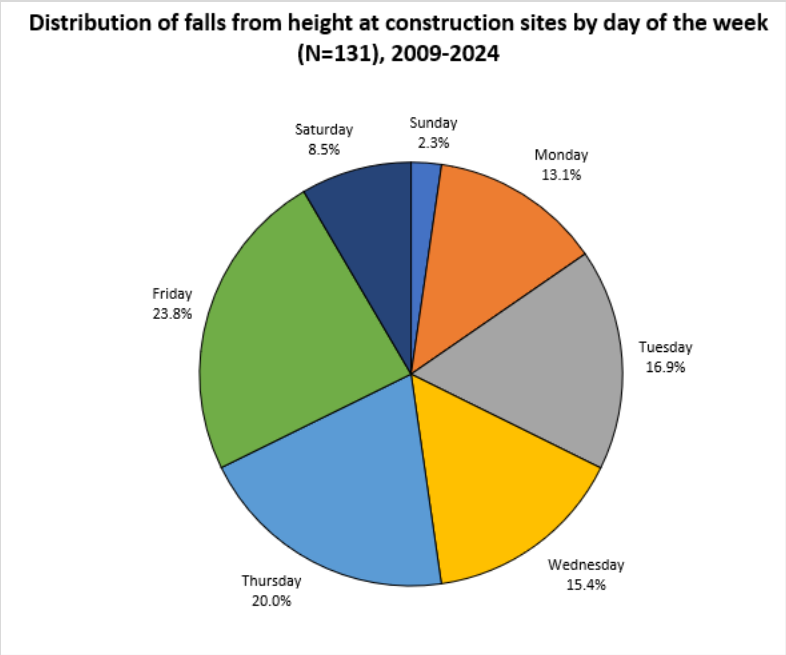

Figure 29: Falls by day of the week, 2009-2024

A similar patten emerged around the falls of the 26 workers reviewed. Approximately 46 percent of all falls occurred between Thursday and Saturday. In this group, Wednesday emerges as a day of significant concern, with 27 percent of falls occurring on that day. Falls on Friday remain prevalent, however, with just under one quarter of falls occurring then.

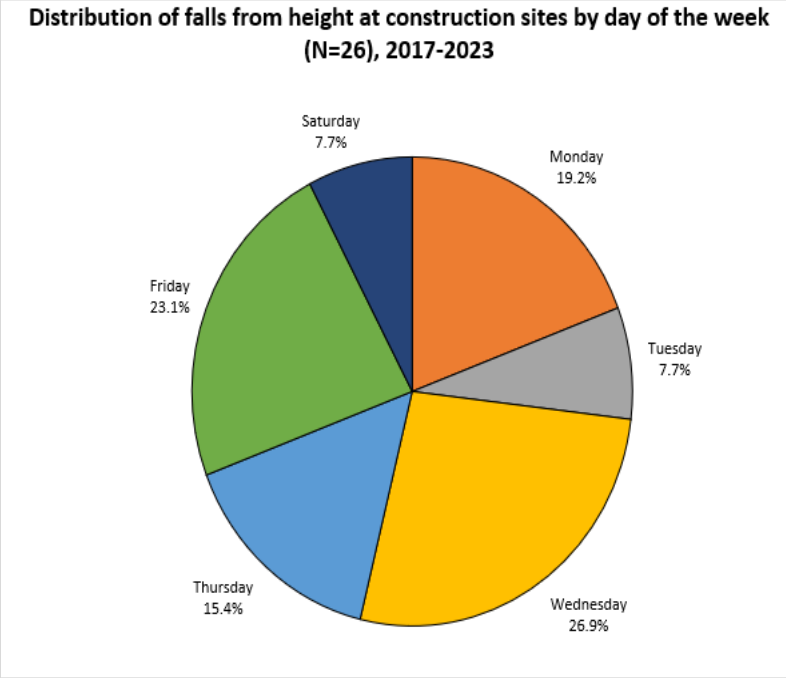

Figure 30: Falls by day of week, 2017-2023

We reviewed the time of day that the 131 workers fell. We were unable to identify the time for 28 percent of the falls in our larger sample. For times of falls that could be identified, the afternoon was a more common time. Of the workers who fell in the morning, one fell before 7:30 am, nine fell between 8 am and 9 am, 12 fell between 9 am and 11 am and 16 fell between 11 am and noon. Of the workers who fell in the afternoon, 18 fell between noon and 2 pm, 13 fell between 2 pm and 4 pm, and 14 fell in the later afternoon after 4 pm.

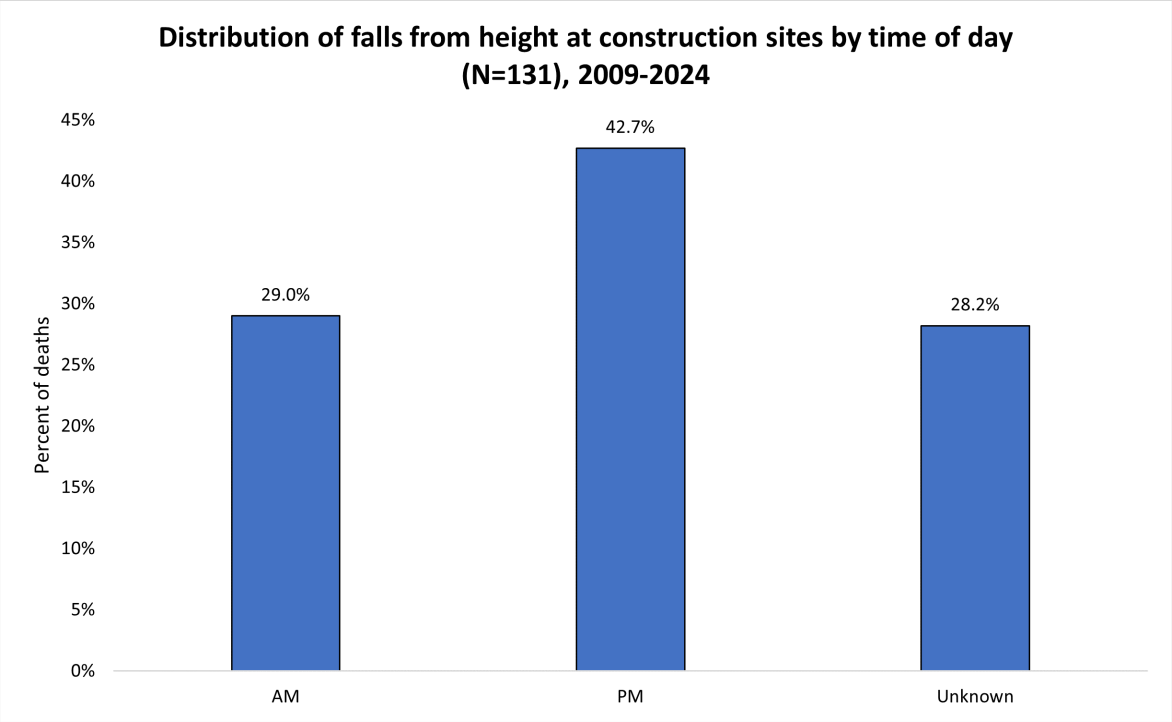

Figure 31: Falls by time of day, 2009-2024

When the times of fall of the 26 workers are considered, the morning was a more common time. In this group, almost 54 percent of workers fell in the morning. Of the 14 who fell in the morning, four fell between 6:30 am and 9 am, seven fell between 9 am and 11 am, and three fell between 11 am and noon. Of the 12 who fell in the afternoon, six fell between 1 pm and 2 pm, two fell between 2 and 4 pm, and four fell after 4 pm.

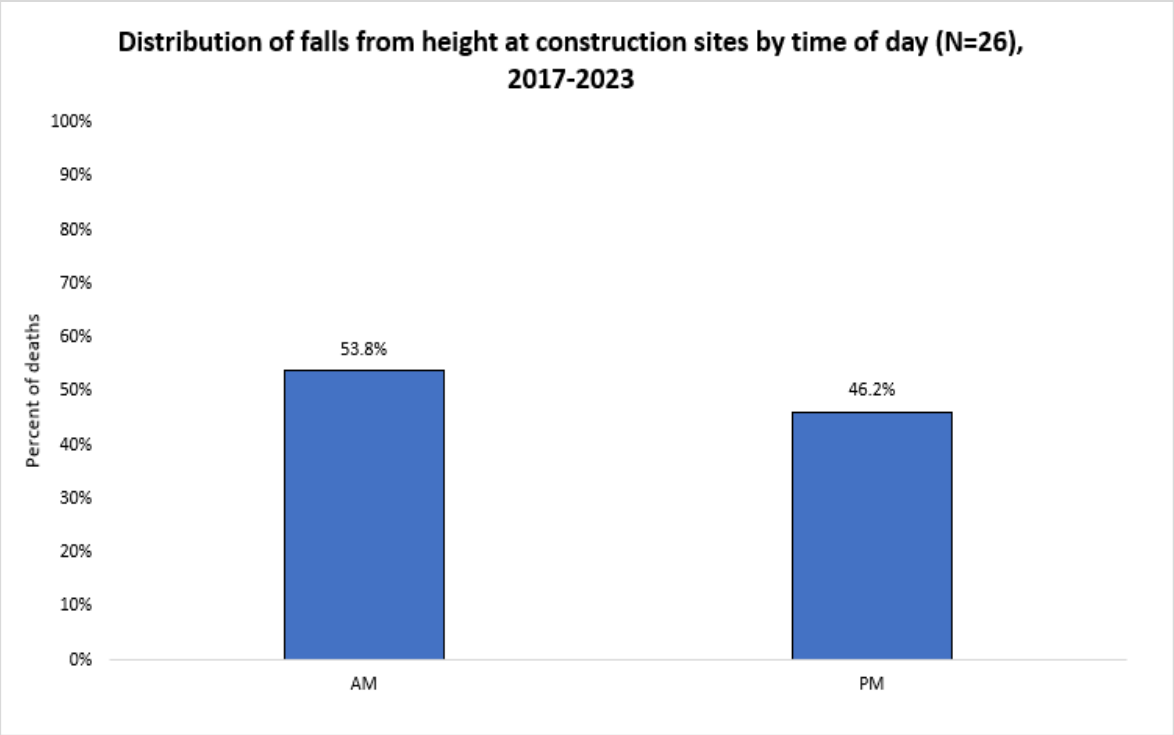

Figure 32: Falls by time of day, 2017-2023

We recognized that in both the larger group of 131 and the group of 26 under review, the mid-morning period between 9 am and noon was the most common and falls generally increase in frequency in the two hours after noon.

Observations

Over recent years, there has been significant focus on educating Ontario's workers about the dangers of working at heights, with apparent success. A 40 percent increase in the number of construction workers between 2010 and 2023 has not led to a commensurate increase in the number of deaths. This speaks to the effectiveness of the health and safety system in Ontario and perhaps to the impact of over a million workers,[22] approximately 92 percent of the workforce over eight years, having taken some form of working at heights training following the introduction of the new training requirements in 2015. Instead of rising with the growing workforce and the increasing hours of work, the number of deaths has remained largely unchanged, which means the rate of death is decreasing. This is a very positive, and very welcome, trend.

[22] Ontario announces additional safety funding; updates working at heights - Ontario Construction News.

Tragically, while expanded education and resources to support workers are intended to prevent tragedy, workers in the construction sector continue to die while at work. While some may attribute these deaths to chance or circumstances beyond one's control, patterns emerge from the data that suggest otherwise and merit further exploration. The first is the overrepresentation of men over 50. Despite typically representing roughly 20 percent of the working population in the construction sector, men over 50 make up almost half of the fall from heights-related deaths. Furthermore, over the past 15 years, men over 50 were more likely to die from a shorter fall than their younger counterparts. This distribution of deaths may be the result of choice on the part of construction employers or the worker themselves to limit older workers to certain heights or tasks. The number of deaths among older workers may be related to issues with physical resilience and aging. It may reflect on the potential risks associated at times with greater experience, including the effects of complacency and overconfidence. Finally, it could underline a culture of expediency and reflect pressure on all workers to complete work more quickly than is reasonably safe. Understanding the culture in which workers operate, particularly the motivation of older workers and how they approach heights in the workplace, may help prevent further deaths in this overrepresented demographic.

Conversely, inexperience also appeared to play a significant role in the deaths in this report. Twenty-six of the 131 workers were within their first year on the job, and four workers were in the first hours of their first day on the job. Three of those deaths were included in the smaller group of 26 deaths and are examined in the next chapter. In some cases, construction was seen as a way to make quick cash without the need for specific skills. Several of the men over 50 came to construction work after a career in something unrelated to construction and, when they died, were working as a sole proprietor, or in a small or family business where the level of supervision may have been less than what would be required for their potentially limited skill level. Issues related to supervision, training, and the assessment of qualifications necessary to work in construction would benefit from further evaluation.

In light of the efforts that have been devoted to education and enforcement, the data on the use of fall protection equipment in this report is concerning, demonstrating a

connection between not using fall protection equipment when working at heights and worker deaths. As noted above, not everyone who died over the past 15 years was required to be using fall protection equipment because they were working under the three-metre requirement. Other workers may not have anticipated needing working at heights training, as their core tasks did not include working at heights. Greater understanding of the contributing issues will allow evaluation of training to better understand which areas to focus upon, worker retention of information, issues with supervision and the strength of the IRS. In many of the deaths we reviewed, if the workers had been required to use fall protection equipment by a constructor, employer or supervisor, or reminded by a health and safety representative, or co-worker, the individuals may be alive today. The potential challenges with effective supervision and the fragility of the IRS, particularly in sole proprietor or small companies, may have been factors in these deaths. Chapter 5 will further discuss this concern with recommendations related to small businesses and supervision.

An additional observation in the review was the increased number of deaths occurring during the Thursday to Sunday period. There may be a number of complex issues that contribute to this observation, including tiredness with decline in attentiveness, the accumulation of hours over a long work week, the potential absence of supervision on site, the pattern of site visits, and enforcement efforts by authorities closer to the end of the week. Further exploration of this observation would likely be beneficial. especially when supported by insight from workers in the construction industry. In particular, consulting those who may have experienced an injury on one of those days may assist in better understanding this trend.

We have not reported on a number of other potential contributing factors, including a worker's primary language of communication (raising the possibility of language challenges), the impact of weather, and toxicological findings. For the first two factors, though there was a potential pattern indicating these could be important considerations, we did not have sufficient data to make a reasonable assessment of the role each may have played in the deaths. We will continue to collect data in these areas and encourage our sectoral partners to develop consistency in the

collection of data, particularly primary language, so that future reports might be able to consider their impact.

Toxicology and potential impairment are complicated. Toxicological testing and analysis of substances found in post-mortem blood samples requires careful evaluation of many factors. The finding of a substance does not simply equate to impairment. Furthermore, ascribing impairment as a contributor to the death may not only oversimplify the analysis or divert attention from the impact of other relevant factors but may also be overly prejudicial from our perspective.

The observations presented in this report would be best assessed and tested against data that the OCC does not collect as part of the death investigation, specifically information relating to workers who survive construction injury events, and to those who are fortunate to have never experienced an injury while on the job. Our colleagues at the MLITSD, IHSA, WSIB and other sector organizations have access to data that could support better understanding the information we have presented in this report in a broader lived context. Only by better understanding the holistic picture will the salience of the patterns identified in this report be determined. We encourage our partners to reflect on the findings from these data as the first stage in a longer conversation about the construction sector and the lives – and deaths – of its workers.

Appendix A – MLITSD Initiatives and Campaigns

The following is a list of fall-related initiatives and campaigns undertaken by the MLITSD over the past 15 years that involved construction:

Fiscal Year	Title	Date	Health & Safety Program Area
2009-2010	Falls Hazards at Construction Sites	January 2010 – April 2010	Construction
2011-2012	Low-Rise Residential (Homebuilder)	May 2011	Construction
2011-2012	Access Equipment (ladders, suspended work platform/stages, elevated work platforms)	August 2011	Construction
2011-2012	Construction Trade Specific (equipment, fall protection, slips, trips and falls)	March 2012	Construction
2012-2013	Slips, Trips and Falls (ladder safety and fall protection hazards)	February 2013-March 2013	Construction & Industrial
2013-2014	Falls Hazards	September 2013 – October 2013	Construction
2014-2015	Fall Protection/Hazards	July 2014 – August 2014	Construction
2015-2016	Worker Safety on Sloped Roof	April 2015 – March 2016	Construction
2016-2017	Falls Hazards	May 2016 – July 2016	Construction, Industrial, Mining
2016-2017	Fall Protection	April 2016 – March 2017	Construction
2016-2017	Worker Safety on Sloped Roofs	April 2016 – March 2017	Construction
2017-2018	Residential Projects	September 2017 – November 2017	Construction
2017-2018	Falls	October 2017 – November 2017	Construction, Industrial, Mining, Healthcare
2017-2018	Fall Protection	April 2017 – March 2018	Construction

2018-2019	Working at Heights – Fall Protection Training	June 2018	Construction
2019-2020	High Risk Traumatic Hazards – Slips, Trips, Falls	April 2019 – July 2019	Construction, Industrial, Mining, Healthcare
2019-2020	Suspended Access Equipment	August 2019 – September 2019	Construction
2023-2024	Falls from Heights in Single Family Residential Construction	April 2023 – March 2024	Construction
2024-2025	Falls from Heights in Single Family Residential and Multi-Family Residential	April 2024 – March 2025	Construction
2025-2026	Single-family Residential and Multi-Family Residential	April 2025 – March 2026	Construction

Table 5: MLITSD fall-related targeted actions involving construction (Initiatives and Campaigns, 2010-2025)

Appendix B – IHSA Initiatives

2010–2014: Foundations and Early Initiatives

- **2010:** IHSA introduced the *Working at Heights – Fundamentals of Fall Prevention* program, aiming to standardize fall prevention training across Ontario's construction sector. This initiative laid the groundwork for consistent safety education.
- **2013:** To enhance practical learning, IHSA unveiled a simulated training roof at its Etobicoke facility, providing workers with hands-on experience in a controlled environment.

2015: Implementation of the Working at Heights Training Standard

- **April 1, 2015:** Ontario's Ministry of Labour, as it then was, mandated the *Working at Heights Training Program Standard*, requiring construction workers using fall protection systems to complete training approved by the Chief Prevention Officer. IHSA's existing program met these new standards, positioning it as a leading training provider.
- **Training Impact:** By the October 1, 2017, compliance deadline, approximately 420,000 workers had completed the training, with IHSA and its network of

over 180 partners delivering a significant portion of these sessions. (Institute for Work & Health).

2016–2019: Evaluation and Measurable Outcomes

- **2017:** The Institute for Work & Health ("IWH"), an independent, non-profit research organization, conducted an evaluation of the working at heights training. The evaluation revealed a 19 percent reduction in lost-time injury claims due to falls from heights between 2012–2014 and 2017–2019. This decline was notably higher than the six percent reduction observed in other Canadian provinces without similar training mandates. (Institute for Work & Health).
- **2019:** A follow-up study by the IWH confirmed that workers retained improved safety knowledge and practices two years post-training, underscoring the program's long-term effectiveness. (Institute for Work & Health).

2018–2025: Enhanced Resources and Digital Outreach

- Falls Awareness Week started in 2018 and since its inception, IHSA included a comprehensive *Fall Prevention Toolkit*, featuring daily themes, safety talks, checklists, and advisories. This toolkit has been updated with new resources each year. Additionally, IHSA produced two fall-related impactful videos under the *Keep Your Promise* campaign, highlighting real-life scenarios to reinforce safety messages.

2024–2025: Addition of See Something, Say Something Campaign

- After an inquest recommendation in 2024, IHSA developed the See Something, Say Something Campaign that was officially launched at its 2024 Annual General Meeting, and continues to be the messaging during IHSA industry events, presentations and monthly Network News.

Chapter 4: Summaries, 26 Deaths

A. A.

On October 8, 2021, 57-year-old A. A. was working his first construction job, at a masonry restoration project in Toronto, Ontario. That morning, Mr. A and a co-worker were setting up materials and tools at ground level to prepare for bricklaying work. Specifically, they were tasked with moving and placing bricks into buckets to be raised to a scaffold using a manual hoist. Although the exact circumstances of the incident were unwitnessed, Mr. A was found by his co-worker, having fallen approximately 3 metres (9.8 feet) from the second storey of the scaffold to the ground below. It was determined that prior to the fall, Mr. A was likely climbing the exterior end of the scaffold by its rosettes and guardrails in order to access the hoist hook. Despite emergency resuscitation efforts, he died as a result of his injuries shortly after arriving at the hospital.

Mr. A was new to the construction sector, having retired from his previous career as an accountant. He had recently opened a construction company with his son. There was no evidence that he received relevant training, including mandatory working at heights training or scaffold-specific training.

AMBROSINO, Gianluigi

On January 8, 2020, 45-year-old Gianluigi Ambrosino was installing security cameras on the exterior of a newly constructed single-family home in Kleinberg, Ontario. He was using an extension ladder that was positioned at the rear of the house above a walkout basement when he fell approximately 6.8 metres (22.3 feet) to the ground below. Two workers working inside the home heard a loud sound but did not see Mr. Ambrosino fall. The workers called the site supervisor, who attended at the project, called 911 and started cardiopulmonary resuscitation (“CPR”). Emergency Medical Services (“EMS”) attended, but despite continued resuscitation efforts, Mr. Ambrosino was pronounced deceased at the scene. It is believed that Mr. Ambrosino lost his footing or stability on the ladder while twisting to the right side to enlarge a hole in the underside of the roof with tin snips. He was found face down with the tin snips in his left hand.

It was determined that the ladder used by Mr. Ambrosino did not belong to his employer. It was reportedly damaged, was not secured at the top or bottom, and was not set up at the required angle. Additionally, the feet of the ladder had ice buildup due to the weather and ground conditions. At the time of the incident, Mr. Ambrosino was not using fall or head protection. While he had received working at heights training, the date of training is unknown, and there was no evidence of additional training such as ladder, scaffold, or elevated work platform training.

An employer was convicted and sentenced on one charge in a prosecution under the *Occupational Health and Safety Act* ("OHSA").

ANDRE, Antonio

On January 19, 2018, 59-year-old Antonio Andre was working as a bricklayer on a residential construction project in Queensville, Ontario. At the time of the incident, Mr. Andre was standing on the second level of a scaffolding platform located 4.5 metres (14.8 feet) above the ground. The scaffolding was insulated by tarps and had a triangular opening in the platform. After hearing a sound, a co-worker discovered Mr. Andre on the ground with no vital signs. While no witnesses observed the fall, Mr. Andre was believed to have fallen through the opening of the platform. He was resuscitated and hospitalized, where he died as a result of his injuries on January 20, 2018.

The opening of the platform was unprotected, and there was no warning to workers of this opening and other safety issues on the scaffold. The site supervisor and third-party safety consultants had identified safety issues on the scaffold in the days leading up to the incident, but these issues were not rectified, nor inspected by a supervisor. In addition, Mr. Andre was not using fall protection equipment. He had also not received working at heights training, though he had received other training relating to working at heights and scaffolding throughout his career.

A supervisor was convicted and sentenced on one charge in a prosecution under the OHSA.

ATAS, Ismail

On June 23, 2023, 30-year-old Ismail Atas was working on a project in Gravenhurst, Ontario involving the new construction of a retirement residence. His company was subcontracted to assist with completing exterior stucco. While operating a telescopic boom lift to prepare drainage channels for stucco work, the boom lift rolled over down a nearby uncompacted sand slope. Mr. Atas reportedly jumped from the lift as it toppled, falling approximately 9.1 to 12.2 metres (30 to 40 feet) to the ground below. He was transported to hospital, where he died as a result of his injuries on June 27, 2023.

Prior to the work beginning, sloping hazards were identified and discussed with Mr. Atas. It was determined that the boom lift should be used so that workers could access the work area without being exposed to these hazards, however, the operating manual for the boom lift indicated that it should only be used on a firm surface. The manual also outlined tipping hazards in circumstances where the boom was extended and used on sloped ground.

AYETTEY, Emmanuel

On July 14, 2021, 48-year-old Emmanuel Ayettey, was working as a roofer on a two-story home in Orleans, Ontario. He was the co-owner of the company hired to perform the roofing work, which was to start and finish that day. At the time of the incident, Mr. Ayettey was using a ladder to transport roof anchors to workers on the roof, which were to be installed as part of a fall protection system. After handing a bracket to a worker on the roof, Mr. Ayettey fell approximately 6.1 metres (20 feet) from the ladder to the ground below. He was not using fall protection equipment. The cause of Mr. Ayettey's fall is unknown, however, his co-workers reported that he had not been feeling well that day and had decided he would not work on the roof itself. EMS transported Mr. Ayettey to hospital, where he died on July 24, 2021.

BARRETT, Daniel

On April 10, 2017, 70-year-old Daniel Barrett was conducting a preliminary scope of work and cost assessment for new duct work in the ceiling of a bank in Kenora, Ontario. Mr. Barrett was the estimator for a company that was subcontracted by the constructor to provide ventilation at the project. To conduct the assessment, Mr. Barrett and the site supervisor for the constructor accessed the top of a bank vault through a stairwell. At the access point from the stairs to the top of the bank vault, between the vault and a false ceiling, there was an opening that was not surrounded by guardrails or any protective covering. Although not using fall protection at the time, Mr. Barrett and a co-worker noted the fall hazards in their assessment and discussed the fall protection that would be used once the project commenced. At the end of the assessment, as he walked towards the stairs, Mr. Barrett stumbled and fell approximately 3.2 metres (10.5 feet) through the opening, landing in the hallway below and sustaining significant injuries. He died in hospital on April 16, 2017, as a result of his injuries.

A supervisor was convicted and sentenced on one charge in a prosecution under the OHSA.

BOUZALAS, Dimitrios

On Friday, November 2, 2018, 57-year-old Dimitrios Bouzalas was working as a general labourer on a project in Toronto, Ontario involving the renovation of an existing structure. Mr. Bouzalas' employer was subcontracted by the constructor of the project to install a new electrical system. At the time of the incident, Mr. Bouzalas and a co-worker were working in rainy conditions, installing PVC conduits on the exterior of the building. Mr. Bouzalas accessed the roof using a ladder they had found on-site in order to store disconnected electrical wiring. The co-worker held the ladder as Mr. Bouzalas descended. The ladder shifted, causing Mr. Bouzalas to fall approximately 3.7 to 4.6 metres (12 to 15 feet) to the ground below. EMS attended and resuscitation was attempted. Mr. Bouzalas was pronounced deceased at the scene.

It was determined that the ladder was not construction grade and was improperly positioned. The work was not supervised, and a supervisor had not conducted

health and safety inspections of the site as required. Mr. Bouzalas had not been provided with formal health and safety training, including specific training on the use of fall protection equipment.

A supervisor was convicted and sentenced on one charge in a prosecution under the OHSA.

DASILVA, Antonio

On December 17, 2019, 60-year-old Antonio DaSilva was working as a general labourer on an interior renovation project at a residential property in Toronto, Ontario. Mr. DaSilva was referred to the job by a friend but had not received relevant safety training and is not believed to have had any previous experience in construction. Mr. DaSilva was standing a few steps up on a ladder when he fell to the floor below. Earlier in the day, he had apparently been instructed to cut a hole into drywall and he used the ladder to access the work area. It is unclear what he was doing on the ladder at the time of the incident and the distance that he fell. A co-worker heard a sound and found him lying on the floor unconscious. He was transported to hospital, where he died on February 9, 2020, as a result of complications from his injuries.

DESPINS, Neil

On January 14, 2023, 36-year-old Neil Despins and a co-worker were working on a commercial roofing project in Belleville, Ontario. At the time of the incident, Mr. Despins was fastening down corrugated metal sheeting on a flat roof. Mr. Despins was using a fall protection system that included a Self-Retracting Lifeline (SRL), a device that automatically extends and retracts to maintain tension as the worker moves and activates a braking mechanism to arrest a fall. He had completed working at heights training. While moving one of the metal sheets, Mr. Despins created an unexpected opening in the roof. Mr. Despins fell through this opening, descending approximately 14 metres (46 feet) to the ground below. While the SRL was designed to engage to prevent vertical descent, the locking mechanism of the SRL did not function as intended. Mr. Despins was pronounced deceased at the scene as a result of his injuries.

It was determined that the locking mechanisms of the SRL used by Mr. Despins, as well as two other SRLs on site, had been exposed to moisture and then had frozen in the cold weather (-14 degrees Celsius), rendering them inoperative. It was further determined that this type of SRL was at risk for malfunctioning in low temperature environments, resulting in a safety alert being issued.

DOUGLAS, Philip

On August 7, 2019, 38-year-old Philip Douglas was working at a project in the Township of Stirling-Rawdon involving the assembly and erection of a barn. Mr. Douglas, a sole proprietor based out of Prince Edward Island (PEI), was hired by the constructor of the project. Mr. Douglas was working from the bucket of a bucket truck to install trusses for skylights inside the barn when he fell approximately 5.5 to 6.1 metres (18 to 20 feet) to the ground below. Although he was experienced in construction work and had reportedly received the equivalent of working at heights training in PEI, he was not using fall protection equipment. Mr. Douglas was transported to hospital by emergency services, where he died as a result of his injuries on August 21, 2019.

The constructor was convicted and sentenced on one charge in a prosecution under the OHSA.

ENGELBERTS, Connor

On June 5, 2019, 36-year-old Connor Engelberts was working on a construction project at a single-family residential property in Carp, Ontario. Mr. Engelberts was employed by the constructor of the project and was a supervisor on site. At the time of the incident, Mr. Engelberts and three co-workers were installing metal panels on the roof of the home's garage. Mr. Engelberts was working from a scaffolding structure that did not have guardrails and was not fully planked. Mr. Engelberts worked his way towards the section of the scaffolding that was not planked and fell approximately 3.3 metres (10.8 feet), striking his chest on the halfway point of the structure before hitting the ground below. His fall was not witnessed by his co-workers. Mr. Engelberts was transported to the hospital by EMS, where he died as a result of his injuries on June 9, 2019.

Mr. Engelberts had completed working at heights training. Following a recent Ministry of Labour, Immigration, Training and Skills Development ("MLITSD") order relating to safety issues with the scaffold, the company held a "safety talk" regarding the safe erection of the scaffold. This discussion noted that the scaffold should be protected by guardrails and fully planked.

An employer was convicted and sentenced on one charge in a prosecution under the OHSA.

GOLSHAN, Ataollah

On March 4, 2020, 65-year-old Ataollah Golshan was working as a painter on the construction of a single-family home in Markham, Ontario. At the time of the incident, Mr. Golshan was descending the stairs from the ground floor into the basement. As Mr. Golshan descended the stairs, he reached for an extension cord hanging about 20 inches beyond the handrail. The handrail was not properly secured to the stairs and failed, causing Mr. Golshan to fall approximately 1.2 to 1.5 metres (3.9 to 4.9 feet) to the basement floor below. Mr. Golshan died in hospital on March 9, 2020, as a result of his injuries.

Mr. Golshan had been referred to work on the project by a friend and had been working with his employer for two weeks on a trial basis. He is not believed to have been provided with health and safety training.

It was reported that the homeowner had hired a family friend to complete the stairs as they found the quote provided by a subcontractor to be too high.

HERNANDEZ-LOPEZ, Jorge Enrique

On January 10, 2022, 27-year-old Jorge Enrique Hernandez-Lopez was working his first day on a project in Essex County, Ontario, involving the construction of a new greenhouse. He was positioned on a vent cart trolley platform, installing weather strips on glass vent panels. The task required kneeling, bending, and leaning beyond the platform's edge to reach and secure the strips using a rubber mallet. Although Mr. Hernandez-Lopez had received working at heights training and was wearing a safety harness, his fall protection lanyard was not anchored at the time, reportedly because it may have restricted his movement. In addition, he was not wearing a hard

hat. Mr. Hernandez-Lopez was found vital signs absent on the frozen ground below, having fallen approximately 7.6 metres (25 feet) to the ground below. The fall was not witnessed, but broken glass nearby suggested he had leaned on a panel that gave way. He was pronounced deceased at the scene.

It was determined that the nature of the task required Mr. Hernandez-Lopez's center of mass to extend beyond the edge of the platform. In the absence of stable support, this created an unstable working posture, increasing the risk of a fall.

An employer and the constructor were both convicted and sentenced on one charge each in a prosecution under the OHSA.

IBARRA, Jose

On May 8, 2021, 52-year-old Jose Ibarra was working on a construction project involving the building of two high-rise condominium towers in Toronto, Ontario. At the time of the incident, Mr. Ibarra was pouring concrete into the vertical walls on the 16th floor of one of the buildings. Mr. Ibarra and his colleagues had constructed elevated work platforms around the perimeter of the room to assist with this task. While attempting to access a different work platform on the other side of the wall, Mr. Ibarra unhooked his fall protection equipment to climb over the wall form, following the actions of his supervisor. As he began to climb over the wall, he lost his footing and fell into a guardrail, which broke. Mr. Ibarra fell approximately 5 metres (16.4 feet) to the concrete floor below. He was pronounced deceased at the scene.

Mr. Ibarra's working at heights training had very recently expired. He also did not receive any site orientation at the project. Furthermore, it was determined that no Job Hazard Analysis was completed to identify and control potential hazards at the site, and that the guardrail in question was overloaded.

MARTIN, Justin

On July 19, 2021, 44-year-old Justin Martin was working on a construction project demolishing an old grain silo in Chatham, Ontario. Using an Oxy-Acetylene torch, Mr. Martin was cutting pieces of structural steel components, including pipes, beams, and columns. The cut pieces would then be rigged to a crane and lowered to the ground. The silo was composed of several platforms of various heights throughout the building. At the time of the incident, Mr. Martin was working on a ladder on a platform approximately 7.6 metres (25 feet) above the ground. The platform had holes in the floor and unguarded openings around three sides. While in the process of removing an old hopper, one half of the hopper dropped suddenly and fell to the platform. This caused Mr. Martin to fall off the ladder and over the edge of the platform, to the ground below, a distance of approximately 7.6 metres (25 feet). He was transported to hospital and died in hospital as a result of his injuries.

Mr. Martin was not using any fall protection equipment. His working at heights training was expired.

An employer was convicted and sentenced on one charge in a prosecution under the OHSA.

MILLSOP, Tracey

On May 3, 2018, 46-year-old Tracey Millsop was assisting with demolition work at a construction site in Ottawa, Ontario. The project involved the demolition and renovation of a three-story duplex. Ms. Millsop was tasked with helping to remove debris from a basement area. The first-floor sheathing had been removed and a makeshift pathway had been installed along the open joists to permit workers to cross from one end of the building to the stairs leading to the basement. The pathway was constructed from 2x8 wooden boards of varying lengths, placed in an overlapping fashion. While leaving for a break, Ms. Millsop was walking along the pathway towards the rear door of the structure when she fell through an opening between two floor joists and became lodged up to her chest and abdomen. Ms. Millsop was assisted and attended to by two other workers. She declined medical assistance and expressed a desire to return home. After leaving the site, Ms. Millsop

lost consciousness and her partner transported her to hospital. She subsequently died in hospital as a result of her injuries.

Ms. Millsop was at the project to assist a personal acquaintance and was not employed by any company involved with the project. It was her first day at the project and she was not provided with any health and safety training.

The constructor and two supervisors were each convicted and sentenced on one charge in a prosecution under the OHSA.

NA, Young Jun

On October 14, 2021, 71-year-old Young Jun Na was working on a residential renovation project in Toronto, Ontario. At the time of the incident, Mr. Na was replacing the roof panels on the backyard patio roof. Mr. Na was positioned on the patio roof, moving the new panels into place, when he fell through an opening in the roof. Mr. Na fell approximately 2.6 metres (8.5 feet), striking his head on the concrete below. He was found immediately by the homeowners and transported to hospital by EMS. Mr. Na died in hospital the next day as a result of his injuries.

Mr. Na had many years of experience owning and operating construction companies. He retired in 2017 but re-registered his business in 2020 to perform renovation work. His working at heights training had expired approximately 3.5 years before the incident. He was not using any fall protection equipment, though the distance of his fall did not meet the three-metre threshold triggering the legal requirement for fall protection.

OOSTERHUIS, James

On October 27, 2020, 45-year-old James Oosterhuis was working as a general labourer at a project involving the construction of a four-story residential apartment in Breslau, Ontario. At the time of the incident, Mr. Oosterhuis was cleaning suites on the third floor of the building. He accessed the balcony of a suite to toss garbage into a bin located at ground level. The guardrails around the balcony were in the process of being installed and had been positioned in place, but not fully secured. The unsecured guardrail was not marked with any signage. When Mr. Oosterhuis accessed the balcony and leaned against the guardrail, it gave way, and he fell

approximately 6.1 metres (20 feet) to the ground below. He was not using any protection equipment. Despite resuscitation efforts, Mr. Oosterhuis was pronounced deceased at the scene.

Mr. Oosterhuis had received working at heights training, as well as other relevant health and safety training. There is no evidence that workers were provided training or instruction regarding safe practices when working around uninstalled or uncompleted guardrail systems.

PAULIC, Rude

On November 4, 2022, 52-year-old Rude Paulic was working on a residential porch framing project in Toronto, Ontario. Mr. Paulic was a carpenter and the owner of a residential framing company. At the time of the incident, Mr. Paulic was installing sheathing on the front porch roof of a single-family home. His co-worker was assisting from the second floor of the house by cutting and passing plywood through a window. Mr. Paulic fell approximately 3.6 metres (11.8 feet) from the roof onto a 5-foot metal T-bar post below, which punctured his abdomen. EMS was called, and Mr. Paulic was conscious and speaking when first responders arrived. He was transported to hospital, where he died as a result of his injuries.

Mr. Paulic had received working at heights training. He was not using fall protection equipment, although it was available on site.

POULTON, Russell (Scott)

On July 30, 2021, 62-year-old Russell “Scott” Poulton was working as a general labourer on a construction project that involved waterproofing the roof of a portable trailer at an elementary school in Binbrook, Ontario. At the time of the incident, Mr. Poulton was on the roof of the portable along with four co-workers. He was walking backward on the roof, rolling out the membrane that was to be installed in the roof seams. As he did so, his co-worker alerted him that the edge of the roof was approaching, however, this warning came too late, and Mr. Poulton fell approximately 3.3 metres (10.8 feet) off the roof to the asphalt ground below. Mr. Poulton was transported to hospital by emergency services, where he died seven days later on August 6, 2021.

Mr. Poulton had received working at heights training. He was not using any form of fall protection equipment at the time of the incident, and neither were his co-workers. His co-workers appeared to believe that fall protection was unnecessary, given how close the roof was to the three-metre threshold triggering the legal requirement for fall protection.

An employer was convicted and sentenced on one charge in a prosecution under the OHSA.

REGULAR, Steven

On April 1, 2021, 45-year-old Steven Regular was working on a roof replacement project at a commercial property in Bradford, Ontario. The roof replacement required the removal of the existing flat roof system, including a pre-manufactured concrete deck and the membrane materials located on top of the deck. The roof membrane materials had been cut into pieces and removed, and the exposed concrete roof deck was being swept and cleared of remaining debris before its removal. At the time of the incident, Mr. Regular was standing on the roof deck, pushing a wheelbarrow of debris toward the disposal shoot, when the concrete roof deck panel beneath him collapsed. He fell approximately 5.2 metres (17.1 feet), landing on the concrete floor below. Mr. Regular was pronounced deceased at the scene.

Prior to Mr. Regular's death, several safety concerns had been raised about the weak concrete roof. Two near-miss incidents had occurred, where equipment and a worker accidentally broke through the roof deck while work was underway. Despite these concerns, work was not stopped, safety precautions were not taken to secure the roof deck, and workers were not instructed to use fall protection equipment while working from the roof.

An employer and the constructor were each convicted and sentenced on one charge in a prosecution under the OHSA.

SCHMIDT, Justin

On October 2, 2019, 19-year-old Justin Schmidt was working on a tree-trimming project at a construction site in Dundalk, Ontario. Mr. Schmidt and his colleagues attended the project in a dump truck equipped with an elevated work platform, or boom truck, which is routinely used for tree trimming. Mr. Schmidt was operating the elevated work platform from the controls located inside the truck's bucket to trim trees that were obstructing the operation of excavators. His co-workers were tending to the fallen limbs, cleaning up debris and placing debris in the woodchipper. Although Mr. Schmidt had not received working at heights training, he was using a fall protection system consisting of a safety harness and shock absorbing lanyard. Witnesses reported that around the time of the incident, Mr. Schmidt appeared to be preparing to stow the boom and bucket of the elevated work platform, when the boom and bucket that he was standing in suddenly dropped approximately 12.5 metres (41 feet) from a near-vertical position. The force and speed of the drop caused Mr. Schmidt to be ejected from the bucket and then abruptly returned by his harness and lanyard, which were attached to the bucket. The bucket crashed down onto the platform area on top of the truck's cab and the impact caused fatal injuries to Mr. Schmidt. He was pronounced deceased at the scene.

It was later determined that the cause of the incident was trapped air inside the bottom hydraulic cylinder of the upper boom, which resulted in the boom falling uncontrollably.

TJIOE, Paul

On October 24, 2022, 70-year-old Paul Tjioe was working on a new home construction project installing multiple garage doors in Hillsburgh, Ontario. Mr. Tjioe was working alone, using a stepladder to complete weather seal work on the garages and to set up garage door openers. Mr. Tjioe reportedly told the homeowner that he had brought the wrong ladders for the type of work he was doing: a 6-foot stepladder and a 20-foot extension ladder, rather than a ten-foot ladder. The stepladder he was using was also observed to be unstable. The homeowner offered to hold it still, however Mr. Tjioe declined her offer. The

circumstances surrounding Mr. Tjioe's fall were unwitnessed. After failing to return home that evening, his family attended the construction project in the early morning hours of October 25, 2022, and located him lying on the floor of the garage. Mr. Tjioe was pronounced deceased at the scene.

Based on observations of the scene, it appeared that Mr. Tjioe had fallen a distance of approximately 1.8 metres (6 feet); however, it could not be determined which ladder he had been using and, therefore, the exact distance of the fall. It was reported that Mr. Tjioe had recently seen a medical practitioner due to dizzy spells and had a history of hypertension.

VEENSTRA, Jason

On March 7, 2019, 25-year-old Jason Veenstra was working as a general labourer and deck installer in Ajax, Ontario, installing metal roof decking on the trusses of a commercial building. He had been employed by his employer for approximately 6 months. At the time of the incident, he was laying the last two metal sheets to close the remaining hole in the roof, when he fell through the opening in the roof to the ground below, a distance of approximately 17.7 metres (58 feet). His fall was unwitnessed. Mr. Veenstra died in hospital as a result of his injuries.

Mr. Veenstra had received working at heights training nine days prior. He had also been provided with other training related to fall protection and health and safety. It was reported that Mr. Veenstra was initially tied off using a self-retracting lifeline. He was advised by his colleague to attach to a different tie-off point while laying the last sheets and had disconnected from the anchor point shortly before the fall. The roof surface was icy and slippery and there were very strong wind gusts. In addition, it was reported that Mr. Veenstra may have been distracted and disengaged on the day in question.

WALL, Gerhard (George)

On April 6, 2022, 22-year-old Gerhard "George" Wall was completing re-roofing work on a two-story residential building project in London, Ontario. While installing a metal roof panel at the rear corner of a sloping metal roof, Mr. Wall fell approximately 7.6 metres (25 feet) onto the paved driveway below. His co-workers saw Mr. Wall land but did not see what caused him to fall. Mr. Wall was not using fall protection equipment and other workers at the site were also not using fall protection equipment, although such equipment was available on site. EMS was called immediately, and Mr. Wall was transported to the hospital, where he died as a result of his injuries on April 8, 2022.

There was no evidence that Mr. Hall had completed mandatory Heath and Safety Awareness Training. Furthermore, no site-specific fall protection training was provided for the project.

The constructor was convicted and sentenced on one charge in a prosecution under the OHSA.

WHEELER, Michael

On January 20, 2020, 61-year-old Michael Wheeler was working as a gas fitter at a project involving the construction of a low-rise residential building in Markham, Ontario. At the time of the incident, Mr. Wheeler was using a 10-foot A-Frame ladder to install a gas pipe, which was to be located 4.3 metres (14.1 feet) above the ground in a garage. Mr. Wheeler fell a distance of approximately 3 metres (9.8 feet) from the ladder, landing on the frozen, unfinished garage floor. There were no witnesses to the incident. Mr. Wheeler was found by a co-worker, who called EMS. He was transported to hospital and died in hospital the next day (January 21, 2020) as a result of his injuries.

There was no evidence that Mr. Wheeler had completed Health and Safety Awareness Training. There was also no evidence that he had received any site-specific health and safety training or that he had been provided with the employer's mandatory orientation training. The ladder he was using was damaged and positioned on uneven ground. In addition, it was determined that the work being done required the use of a scaffold or elevated work platform rather than a ladder.

Chapter 5: Review of Findings and Observations, 26 Deaths

This chapter focuses on the specific circumstances of the tragic fall deaths of 26 construction workers between 2017 and 2023. In each of the 26 deaths under review, the worker had a reasonable expectation of safety in the workplace. That expectation was undermined as a result of specific issues, notably supervisory challenges, ineffective policy or practice, equipment malfunctions or unfortunate decisions. The stories of their deaths serve as cautionary reminders of the devastating outcomes that can result when care is not taken to ensure that those you employ, supervise, and work alongside are not protected by strong health and safety policy as well as consistent daily practices.

Through review of the 26 deaths in aggregate, we are able to see the systemic issues and gaps in process and policy that connect them. This chapter is a first step towards a sector-wide root cause analysis. As we conduct further reviews, we hope to deepen our understanding of the sector and be better able to isolate attitudes, practices and policies that will inform the necessary conditions for a change in policy and practice at multiple levels: individually, for different workplace parties, locally among companies of all sizes, and systemically throughout the broader health and safety environment.

We have provided seven recommendations in this chapter. The recommendations are interspersed in the text, rather than collected at the end of the chapter. By presenting the recommendations alongside the stories that prompted the Advisory Committee to make them, we aim to provide the context necessary to understand why each recommendation was believed to be essential. Ultimately, the recommendations in this chapter are aimed at ensuring others do not suffer similar, preventable tragic outcomes.

The Review Process

Reviews of the individual deaths are conducted using investigative files (“briefs”) prepared by the Construction Death Review (“CDR”) Secretariat (the “Secretariat”). CDR briefs include material generated by inspectors from the MLITSD (“Ministry of Labour, Immigration, Training, and Skills Development”) and by coroners in the Office of the Chief Coroner (“OCC”). MLITSD inspector information includes incident-

specific photos, measurements, and witness statements and in addition, investigative findings related to workplace parties and their roles, health and safety policies, and any technical documents required to understand any tools, machinery or equipment involved. Coroner information includes medical assessment of the cause of death, post-mortem examination findings, and a toxicology testing report. The Advisory Committee also received recommendations from previous falls-related inquests.[1] The combination of the material provides a comprehensive overview of the circumstances on the day of the incident and a solid base from which to examine the circumstances of the workers' deaths.[2]

The review of the individual deaths is the responsibility of the CDR Advisory Committee, supported by the Secretariat. To begin the 2025 review, the Secretariat identified all the falls from heights deaths that had not been subject to an inquest and for which MLITSD investigations and prosecutions were complete. Briefs were assembled, and the Executive Lead of the Secretariat, under the direction of the Lead Coroner and the Manager (CDR), assigned case briefs to each Advisory Committee member. Each Advisory Committee member was assigned at least two workers' deaths as the primary reviewer and at least two different deaths as the secondary reviewer. Assigning both primary and secondary responsibility ensured that each worker's death was examined by at least two Committee members, subjecting each death to a diverse range of expertise and perspectives.

For each of the 26 deaths, primary reviewers completed case review templates ("CRT") outlining key information about the person who died, the workplace parties involved, and the circumstances of the death. Secondary reviewers assessed the CRT for completeness and accuracy and, in collaboration with the primary reviewer, the CRT was prepared for discussion with the broader Committee. The discussion,

[1] For example, in 2024, the Inquest Unit at the OCC conducted two falls-related inquests, including the Inquest into the Deaths of William Bruin, Norman Gerrard and Willian (Dean) Maguire (February) and the Inquest into the Deaths of Hani Habib-Ptris and Alcides Jose Moyano (January). Many of the recommendations from those inquests were relevant to the issues explored by the Committee, including the culture of complacency in the construction sector. The recommendations can be found on the *2024 Coroner's Inquests' Verdicts and Recommendations* webpage at https://www.ontario.ca/page/2024-coroners-inquests-verdicts-and-recommendations.

[2] CDR briefs in this report vary in size from three to four hundred pages to just under 1,800 pages. Each Advisory Committee member would have been responsible for approximately 2,500 pages of evidence as a primary and secondary reviewer.

led by the Lead Coroner and supported by members of the Secretariat, took place in-person over the course of a nine-hour meeting in February 2025. Each primary reviewer presented on the worker's death, offered their expert assessment on the issues contributing to the death, and provided guidance on potential recommendations at both the individual and systemic levels. Group discussion after each presentation permitted Committee members to contribute additional expertise to the assessment of each death.

The Advisory Committee met three additional times between March and May, for approximately four hours each time, to determine and discuss the key systemic issues surfaced by the presentations and discussion. The Committee identified five areas of concern or potential improvement:

1. Strengthening Health and Safety Compliance
2. Enhanced Supervision for Workers Working at Heights
3. Worker/Supervisor Education and Training
4. Homeowner and Small Business Education
5. Case Studies in Training Courses

The recommendations provided were derived from the Committee's discussions over the four sessions.

It is important to note that, with rare exceptions, MLITSD and coroner's investigations were conducted without the opportunity to hear from the individuals who died. This limits our ability to fully understand what happened from the worker's perspective and how their actions or the actions of constructors, employers, supervisors, or co-workers may have contributed to their death. The observations in this chapter were based on the review and analysis of incident reports, witness statements, and site conditions. Therefore, certain patterns identified, and observations made in this chapter may be speculative, based on the information available.

Each worker's story highlights specific issues with policy or practice. We have selected the most representative examples to illuminate the issues identified. This may give the impression that one issue singularly contributed to the worker's death. However, it is important to note that in many of the deaths reviewed in this chapter, multiple problems occurred and any one of them may have contributed to the

death. As a result, while each individual may be referenced only once or twice, each of their experiences could have been related to multiple issues outlined.

1. Strengthening Health and Safety Compliance

Ontario has taken steps to build and enforce a robust and effective health and safety environment. While there has been a declining death rate in the construction sector, issues of concern remain. It is recognized that at times parties are not meeting their legislated duties and non-compliance with these duties remains a leading contributor to deaths. This section will focus on three root causes that undermine a culture of safety:

1. In many of the deaths, a combination of age and experience left workers unaware of or overconfident with regard to the risks, leading to a false sense of security. On one hand, a worker with limited experience may look to others as an example of what should and should not be done to complete the task, regardless of training. On the other hand, a worker with many years of experience may believe that familiarity with a task or an environment reduces the likelihood of harm. In a number of deaths, choices made by the constructor, employer, or worker not to comply with the mandatory health and safety requirements unfortunately contributed to workers' deaths.
2. A culture of complacency or heightened risk tolerance can leave workers desensitized to the significant risks that working at heights can pose.
3. Working conditions may compel a worker to forgo safety precautions because those precautions are believed to prevent them from performing the tasks efficiently or effectively. In these instances, the Internal Responsibility System ("IRS") breaks down, leading to the normalization of unsafe practices and a diminished sense of urgency around compliance.

<u>Risks Related to Inexperience</u>

In Chapter 3, we noted that inexperience appeared to be a factor in many fall-related deaths. In this review, inexperience is interpreted as new to a site or new to the construction industry. Our review demonstrated that there are several avenues for the inexperienced to find themselves on a construction project. Small and family-

owned businesses may rely on the labour of inexperienced individuals out of necessity, unable to pay skilled labour to perform routine tasks. Many businesses may use temporary labour with reduced costs or to cover routine tasks, allowing the more skilled workers to focus on the key project goals. The hiring of temporary or casual workers, by itself, is a standard practice. However, the inexperienced workers discussed in this section, once on site, do not appear to have been provided with health and safety instruction or received a level of supervision appropriate to their experience level. New to the sector and left alone to navigate the unfamiliar environment, the workers were likely unaware of the many risks surrounding them.

There are several deaths that could be considered in this section. However, the deaths of A. A. (57) and Russell Poulton (62) in particular highlight how inexperience can limit knowledge of safe work practices, especially on sites run by family or absent supervisors. Both individuals were new to construction or new to their worksite. Neither of them had the experience to understand even the least dangerous risks of the work they were doing. Moreover, given their experience levels, each likely should have been working with supervision. For differing motivations, including assisting a family business or financial advancement, both found themselves in an environment foreign to them without the tools to successfully navigate.

Mr. A was working on a restoration project at the time of his death. He was a retired accountant with only two months experience working in construction, which he had gained after opening a construction company with his son. He had no prior construction experience or working at heights training. On the day of the incident, he was tasked with preparing the worksite for bricklaying, which involved moving and placing bricks into buckets to be raised to a scaffold using a manual hoist. An MLITSD ergonomist who examined the circumstances determined that Mr. A was likely climbing the exterior end of the scaffolding by the rosettes and guardrails to access the hoist hook and may have slipped, resulting in him falling to the ground. It is likely that due to Mr. A's limited experience working on scaffolds and with the associated risks, he was unable to accurately assess the dangers of the work he was performing.

Mr. Poulton was a new employee who had been working four months with his employer. He had received working at heights training in April 2021, two months before he died. He was tasked with installing the roof membrane on portable trailers with a crew of workers. Mr. Poulton was rolling out the membrane for his co-worker to install the final adhesion to the structure. Mr. Poulton did this while walking backwards, and he fell off the edge of the roof. Co-workers' witness statements confirmed that this was not the normal procedure for the task, and that rolling it out facing the direction of travel would provide better control and awareness of the fall hazard. Despite observing his approach, Mr. Poulton's co-workers did not correct his process, only calling out as he got too close to the edge of the roof. Perhaps Mr. Poulton's age may have led his co-workers to assume that he had extensive experience, potentially resulting in a reluctance to correct him out of deference for his seniority. It is possible that both Mr. A. and Mr. Poulton might have survived had someone intervened and addressed their unsafe practices.

Without effective training, mentorship, and supervision, newer workers may not fully recognize the dangers associated with certain tasks or may lack the confidence or job security to question unsafe practices. These deaths speak to the dangers of inexperience but also the dangers of absent and ineffective guidance. Each of them engaged in practices that a culture of safety and supervision would have supported being flagged as risky. They would likely have benefited from more active training and supervision commensurate with their level of experience. Left without effective supervision and guidance in dangerous environments, they unknowingly engaged in risky behaviour that ultimately led to their deaths.

Risks Related to Experience and Complacency

While inexperienced workers may be unaware of significant safety risks, more experienced workers familiar with their work environment may grow complacent and, as a result, underestimate risks. Similar to the section above, there are several deaths under review that illustrate the dangers of complacency. In each of the deaths detailed below, the worker proceeded while aware of the risk, and in some instances noted the risk to a co-worker or companion.

Daniel Barrett was 70 years old at the time of his death, with 40 years of construction experience. He was working as an estimator for a Heating, Ventilation, and Air Conditioning (HVAC) company preparing a quote for the construction of a secure deposit and ATM room at the front of a bank. On the day of the incident, Mr. Barrett met with the site supervisor at another worksite and agreed to meet later in the morning to review the scope of the work at the bank. Mr. Barrett and the site supervisor accessed the top of a bank vault through a stairwell. Between the vault and a false ceiling, there was an unprotected opening. The site supervisor noted the fall hazard and the need for fall protection to complete the work safely. The lighting in the work location was poor, and debris cluttered the floor. As they were exiting the vault, Mr. Barrett may have tripped and fell through the ceiling tiles. The MLITSD investigation noted that the poor lighting would have made identifying the hazard difficult. Mr. Barrett and the supervisor knew the risks and identified and discussed the potential fall hazards just prior to entering the site, but despite this proceeded onto the roof the vault.

Philip Douglas, 38 years old at the time of his death, was an experienced self-employed assembler of barns and very comfortable working from the bucket of a bucket truck. On the day of the incident, he was installing trusses for skylights in a barn when he fell to the ground below. In an interview with the MLITSD while in hospital before he died, Mr. Douglas explained that he removed his fall protection equipment due to discomfort in the 25-degree heat, although he had fall protection equipment with him at the time. The MLITSD's investigation also revealed that the crane used to move the trusses into place had a hook with a defective safety catch, which may have forced Mr. Douglas to exit the lift bucket to manually detach the trusses. The combination of not wearing fall protection and leaving the safety of the bucket put him at serious risk of falling. Despite these hazards, Mr. Douglas appeared comfortable working without protection, suggesting a level of complacency due to his familiarity with the task.

Familiarity and risk desensitization may have been issues in Rude Paulic's death. Mr. Paulic was 52 years old at the time of his death and had been working in construction for most of his life. He was a carpenter and the owner of a small construction company with two employees. Mr. Paulic was working framing a front

porch of a single-family dwelling alongside one of his employees. After completing the framing, Mr. Paulic climbed onto the roof to install the sheathing. One of Mr. Paulic's employees noted that both he and Mr. Paulic were comfortable without fall protection at shorter heights. Although Mr. Paulic had working at heights training and was aware of the three-metre threshold, both his employees noted they often only used fall protection equipment on higher roofs, feeling that lower roofs did not require the extra precaution. Moreover, the workers felt, since they had done the job many times before, there was no need for a safety talk before commencing the work. On the day of the incident, the employee reportedly heard tools falling and climbed onto the front porch roof. He discovered Mr. Paulic had fallen from the roof onto a five-foot long metal T-bar post used for snow fencing. Had he been wearing fall protection, he may have survived the fall.

Complacency was also apparent in the circumstances that led to the death of Gianluigi Ambrosino. Mr. Ambrosino was 45 years old at the time of his death and had 24 years of experience installing security systems. On the day of the incident, he was working unsupervised, installing one of eight security cameras into the soffit on the exterior of a newly constructed single-family home. To complete the task, Mr. Ambrosino was using a damaged 10-foot extension ladder that was extended to 15 feet. It was not secured at the top or bottom and a basement walkout prevented Mr. Ambrosino from setting up the ladder at an appropriate angle. MLITSD inspectors determined that the ladder was positioned in a way that required Mr. Ambrosino to lean and twist to the right for camera installation, increasing the risk of slipping or losing balance. The weather conditions were frigid with ice and snow buildup found on the feet of the ladder. All of these issues increased the risk of a fall. As he was likely confident and comfortable with the work, Mr. Ambrosino may have been desensitized to the risks, and, therefore, underestimated them.

Michael Wheeler, 61 years old at the time of his death, was a gas fitter with 15 years of experience working in the construction sector. On the day of the incident, Mr. Wheeler was installing a gas pipe in an unfinished garage with an uneven frozen dirt surface. He was working from a 10-foot A-frame ladder to install a pipe at about 14 feet above the ground, which meant that he would have been at, or very near, the top of the ladder. The MLITSD's investigation concluded that the job required a

scaffold, not a ladder, and his co-workers felt that the work should have been halted until the correct equipment could be installed. Despite Mr. Wheeler's extensive experience with this type of work, there was no evidence to suggest he had received any site-specific training, though he had the appropriate documentation for working at heights. Mr. Wheeler had likely been in similar situations in the past and may have felt comfortable moving forward with the task.

Each of the individuals in this section were highly experienced and had probably encountered equally or more difficult circumstances previously. In each case, the decision to proceed was likely based on their confidence with the skills they possessed and a desire to get the job done expeditiously. For example, Mr. Barrett had met the supervisor while working at another job earlier in the morning and agreed to meet later that morning to review the bank job. This appears to be a chance meeting that led to an impromptu site visit, exemplifying haste to get the job started. Unfortunately, experience appears to have led to confidence and complacency that may have diminished the workers' abilities to recognize and respond to risk.

High Risk Tolerance

As all the deaths in this review demonstrate, construction can be a dangerous occupation and risks are often an inherent part of the job. Our review brought to light examples where high-risk tolerance contributed to the death of a worker. A willingness to take risks, by itself, is not a precondition for an incident or death. However, left unchecked by appropriate supervision or a functioning IRS, high risk tolerance leaves a worker exposed to injury or death. The Advisory Committee found that workers and supervisors may have become desensitized to ongoing hazards in their environment, accepting them as routine rather than recognizing them as serious threats to safety. Several deaths, including Gerhard Wall, Justin Martin, Jorge Enrique Hernandez-Lopez, and Paul Tjioe, are illustrative of the dangers of higher risk behaviour.

Gerhard (George) Wall was 22 years old at the time of his death and was working alongside his company co-owner installing metal shingles on a single-family dwelling. Although Mr. Wall was young, he had several years of experience with

metal roof installation work. Mr. Wall was working on the corner of the roof without the use of fall protection when he fell to the driveway below. Witness statements indicate that the health and safety culture on site was relaxed, with a pattern of workers not wearing fall protection or other Personal Protective Equipment ("PPE"). Though the constructor noted that he had provided verbal warnings about the use of fall protection "10-20 times over the year", further action was not taken, despite the constructor's own health and safety manual prescribing contract termination after a fourth warning. We do not know what caused Mr. Wall's fall, but his approach to not using fall protection equipment, combined with the constructor's lack of discipline for non-compliance, both likely contributed to Mr. Wall's death.

Justin Martin's death appears connected to the employer's need for someone willing to take on riskier tasks. Mr. Martin was 44 years old at the time of his death and had what his employer believed was 10 years of experience. He had received working at heights training, however, the training was out of date and had not been renewed. A co-worker described him as a "bit of a daredevil," confident in his ability to safely navigate the environments in which he worked. On the day of the incident, he was working on a platform about 25 feet from the ground removing an old hopper from a grain silo. Mr. Martin was making cuts to structural steel components of the hopper using a torch. He was doing this while standing on a ladder that was leaning against the hopper. Much of the equipment that he was using, including the ladder he was standing on and the torch he was using to cut the hopper, was in poor condition. Despite the risk, Mr. Martin was not using fall protection equipment, or any other PPE, and security footage shows that he had not been using fall protection throughout the day. His supervisor was present while Mr. Martin was working unsafely and did not direct that Mr. Martin work in accordance with the *Occupational Health and Safety Act* ("OHSA"). As he finished the final cut, the hopper fell suddenly, causing Mr. Martin to fall 25 feet to the ground. In hindsight, Mr. Martin's employer provided his belief that his company probably should not have taken the job. Multiple factors contributed to Mr. Martin's death, many of them likely part of the role of the supervisor/employer.

In at least two deaths, those of Jorge Enrique Hernandez-Lopez and Paul Tjioe, willingness to accept heightened risk did not appear to be driven by personal

tolerance for risk but by financial considerations. Mr. Hernandez-Lopez was 27 years old at the time of his death. He was a Temporary Foreign Worker from Mexico seeking to establish a life in Canada. He saw the job involving the construction of a new greenhouse as an opportunity to make a good wage. On the day of the incident, his task required him to climb into an elevated vent trolley above the greenhouse, and to kneel, bend and lean over glass vent panels in front of his work area and slide weather strips into place with one hand, while using a rubber or plastic mallet to tap the strip into place with the opposite hand. Although Mr. Hernandez-Lopez was wearing a safety harness at the time, it was not secured to an anchor point. Witnesses presumed Mr. Hernandez-Lopez was finding it difficult to complete the task while wearing the safety harness, as it limited his range of motion. The reason he was finding it difficult was known to the constructor's Health and Safety Representative, who stated to the MLITSD inspector that shorter workers would have to lean closer to the glass to install the weather strips at the top of the glass. This placed the worker closer to the pane of glass and at greater risk of breaking the glass. Mr. Hernandez-Lopez was 5'2". According to one witness, who was also a friend of Mr. Hernandez-Lopez, he wanted to work fast and may have prioritized productivity and completing the task faster, given that remuneration for the position was performance based, with workers earning $1.88 for each vent installed. Despite warnings from his supervisor and the pleading of his co-workers to wear the fall protection and to avoid leaning on the glass to perform the task, Mr. Hernandez-Lopez continued to do both without successful intervention.

Paul Tjioe was 70 years old at the time of his death. He was a self-employed independent contractor, working as a subcontractor to install garage doors on a new home construction project. Approximately 90 percent of the work performed by Mr. Tjioe was through a subcontract with the project's garage door contractor subcontracted by the constructor. The garage door contractor had confirmed in the work order to Mr. Tjioe that a 10-foot ladder was needed for the work. On the day of the incident, he brought a 20-foot extension and a six-foot stepladder with him to complete his task. Investigations could not determine which ladder Mr. Tjioe was using at the time of the incident, as it was noted that Mr. Tjioe's son had moved one of the ladders while attending to his father. In conversation with the homeowner, who, with her husband, was the constructor of the project, Mr. Tjioe acknowledged

that he had brought the wrong ladder but declined the homeowner's offer to hold it when she noticed it appeared unsteady. Based on the height of the rails and opener motor, it appeared that Mr. Tjioe would have fallen from a height of six feet, and therefore may have been standing on the very top of the six-foot ladder, which was the likely cause of his fall. The Advisory Committee theorized that Mr. Tjioe may have decided to continue with the installation because of his extensive experience working with the garage contractor and performing this type of work. But he also had a financial motive to continue with the work. The service call was billed at 1.5 hours. To leave and return would have limited the earnings for the day. The combination of his experience and desire to maximize his earnings for the job may have combined to make the risk of using a shorter ladder acceptable.

As these four deaths demonstrate, high-risk tolerance or risk de-sensitivity can emerge from varying motivations. Each of these deaths were likely, in part at least, the product of the worker's willingness to accept a level of risk. But it is important to acknowledge that other workplace parties were present, did not effectively intervene and allowed the workers to persist, even though in every case, the employer or the constructor knew that allowing them to continue was dangerous. They were as willing to engage in high-risk behaviour. Sadly, the workers bore the consequences of that decision.

Working Conditions

Working conditions and the work environment contribute to a worker's assessment of risk and condition the worker's actions. In some cases, the worker may see themselves as safe, protected by railings or barriers. In other cases, though the working conditions may not be safe, the worker may make the assumption that they are working safely and are therefore protected from the worst outcomes. In the deaths of James Oosterhuis, Ataollah Golshan, and Tracey Millsop, there were issues with communication related to unsafe working conditions. Where the hazards existed, there was no signage indicating there was a potential danger.

Mr. Oosterhuis was 45 years old and was sub-contracted to clean up suites on the third floor of a building. He accessed the balcony of a suite to throw garbage into the bin located at ground level. Permanent guardrails were in the process of being

installed and had been erected but not secured in place. Mr. Oosterhuis made contact with a guardrail as he dropped the garbage over the side of the balcony. The railing gave way and Mr. Oosterhuis fell 20 feet to the ground. Mr. Oosterhuis may have been unaware that the guardrails on the balcony were not secured. The constructor indicated to the MLITSD inspector that he thought Mr. Oosterhuis was experienced enough to not go out on the balcony. It may have been that this assumption did not lead to Mr. Oosterhuis being provided guidance by the constructor about the use of fall protection while on balconies. It may also explain why signage was not posted to indicate that the rails were not secure. Mr. Oosterhuis had received working at heights training a few months before his fall and would have been instructed in the hierarchy of controls. It is also possible that he felt as protected as he needed to be given the presence of the guardrails.

Mr. Golshan, who was 65 at the time of the incident, died as a result of an unsecured railing. It is not certain if Mr. Golshan had any experience in construction, but he had been with his employer for approximately 10 days, having been referred to the employer through a family friend. The employer had committed to "trying him out." On the day of the incident, he was painting finished drywall. He was descending stairs into the basement when he observed an extension cord hanging in the stairwell. Mr. Golshan leaned over the railing to grab the cord. The railing had been built by a family friend of the homeowner (who had decided that the quote offered by the contractor's preferred subcontractor was too expensive). The credentials of the family friend are unknown, but the railing was not secured to the stairs and Mr. Golshan fell approximately 1.2 to 1.5 metres (4 feet, 2 inches to 4 feet, 9 inches) to the basement floor. Leaning over a railing is risky behaviour. The homeowner appeared to have been trying to save money on the cost of the railings and hired someone who the constructor did not recommend and who did not secure the railings. It is not clear that anyone knew that the railings were a hazard, but Mr. Golshan, who had little experience on this site, clearly did not know.

Tracey Millsop was 46 years old and a transient worker seeking to boost her income. She had contacted a personal acquaintance who was a supervisor at a construction company that had been subcontracted to assist with the demolition of a residential home. The supervisor determined that she was not qualified to conduct the

demolition, but could assist with the cleanup, and offered her the opportunity to make some cash under the table. She had no health and safety training and had not previously been on a construction site. The site was supervised by an experienced carpenter, though he too had no formal health and safety training and for the most part was not on site, concentrating on logistics and sub-trade coordination. The site was unsafe with first-floor sheathing removed with an unsecured, makeshift pathway of 2x8 boards of different lengths connecting the front door to the basement, where Ms. Millsop and her partner were to be working to remove waste material and debris. Contrary to health and safety regulations, the pathway did not cover the floor and left an open hole and floor joists exposed. No fall protection was provided or required on site. No signs or warnings about traversing the boards were provided to the workers on the site, possibly because the demolition company was staffed by experienced workers who were used to navigating such an environment. Ms. Millsop and her partner walked the board pathway to reach the basement. At break time, Ms. Millsop was exiting the worksite along the board pathway when she fell through the open floor landing on her ribs on a floor joist, causing rib fractures and liver injury. She decided to leave to return home rather than await an ambulance and died as a result of her injuries shortly after leaving the worksite.

Mr. Oosterhuis, Mr. Golshan, and Ms. Millsop were inexperienced and their deaths could have been highlighted in the “Risks Related to Inexperience” section above. All three required more supervision than they were provided and appeared to be unprepared to assess the risks of certain actions. As importantly, the appropriate training or necessary warnings that the sites were hazardous places that needed to be navigated with care were not provided. All three work sites were unsafe. Inexperienced workers would likely not have had the ability to identify this, nor the confidence to challenge the lack of safety if they were able to identify the safety hazards.

Equipment Failure

Neil Despins (36) was unaware that the fall protection he was relying upon, and using properly, would fail to protect him. Mr. Despins was a roofer installing corrugated metal sheeting on a flat roofed industrial building on a very cold January (-14 degrees Celsius) day. He was using fall protection that included a self-retracting

lifeline ("SRL"), allowing ease of movement to complete his task. In seeking to free a sheet that had become trapped, he inadvertently shifted the sheet upon which he was standing, creating an opening through which he fell. Unfortunately, Mr. Despins' SRL did not engage as intended and he fell 46 feet to the ground. Upon examination, the MLITSD discovered that the locking spool mechanism of the SRL had frozen, rendering it inoperative after the SRL had been left outside overnight in the freezing temperatures. All components of the fall arrest system were not likely thoroughly inspected and tested on the ground. Following Mr. Despins' death, the MLITSD released an alert noting that the spool and locking mechanism on this type of SRL may freeze if the SRL is stored outside in a cold area overnight. It recommended that all SRLs be tested daily before use and to avoid leaving the unit exposed to freezing conditions during storage.[3]

From the perspective of the worker, Mr. Despins used the appropriate fall protection equipment or thought he was protected under the hierarchy of controls. All of the deaths in this section show that non-compliance results from different factors, some personal, some situational, some a product of work culture and site organization. Without the ability to ask questions of the workers who died in these incidents, there are many answers we will never know. It would be beneficial to conduct further evaluation of the perspectives of those who survive falls from heights to get a better understanding of individual motivation.

To facilitate this, the OCC recommends the following:

RECOMMENDATION 1:

To the Ministry of Labour, Immigration, Training, and Skills Development ("MLITSD") and the Chief Prevention Officer ("CPO"):

1. Explore and analyze why non-compliance with the working at heights training and/or fall protection regulatory duties contributed to the 26 deaths under review. Through the learnings from the information obtained and analysis, strengthen strategies to enhance compliance.

[3] https://www.ontario.ca/page/alert-working-heights-construction-using-self-retracting-lifelines-leading-edge-srl-le-locking-mechanisms. The IHSA has also released additional directions regarding the safe use of SRLs. See "Self-Retracting Devices with Leading Edge Capabilities" at W255.pdf.

2. Enhanced Supervision for Workers Working at Heights

A recurring theme identified across many of the deaths reviewed surrounds gaps in supervision and the promotion of a safety culture. As noted in earlier chapters, working at heights remains one of the most hazardous activities in the construction industry. Effective supervision is critical to ensuring that safety protocols are consistently followed and that workers are adequately protected. Supervisors play a vital role in reinforcing the use of fall protection equipment, assessing and responding to environmental risks such as hazardous weather conditions and facilitating regular toolbox talks. Without this oversight, the risk of serious incidents increases.

Our findings underscore the importance of effective supervisory practices in the prevention of workplace deaths. According to subsections 14 (1) and 15 (1) of Ontario Regulation 213/91 (Construction Projects), small projects involving fewer than five workers do not require the appointment of a supervisor. These projects generally rely on direct supervision by the constructor and/or employer. Thirteen workers reviewed in this report worked on crews of fewer than five workers and two were single person operations. Working alongside the employer, who may have been focused on specific tasks and not actively supervising the worker, may have contributed to the incident that led to a worker's death. Conversely, the presence of a person in a dedicated supervisory role may have been instrumental in preventing that death. The following case reviews will illustrate how gaps in supervision highlight the critical need for consistent and effective oversight in high-risk work environments.

Importance of a Culture of Safety

The cultivation and reinforcement of safety culture on the job site is essential to protecting workers in high-risk environments. This culture is shaped not only by formal policies but also by daily practices, supervisory behaviour, and the consistent reinforcement of safe work procedures. In reviewing several deaths, it became evident to the Advisory Committee that safety was not embedded as a core value on some job sites.

Effective safety management relies on visible leadership, regular toolbox talks, and compliance with health and safety policies for all workers on a site. When unsafe behaviors become normalized through routine shortcuts or lack of corrective action, they can set a precedent that risk-taking is acceptable. In Mr. Jose Ibarra's death, unsafe behaviours emerged to compensate for challenging workplace design. Mr. Ibarra was assisting in the building of walls on a high-rise. He and his two partners were working on a scaffold on two walls connected at a T-junction. To access the scaffold running north and south, safe practice required the workers to climb down from the east-west wall via ladders, walk around to the other side of the north-south wall and reascend. Perhaps to avoid the time that descending and reascending would take, Mr. Ibarra's foreman was observed removing his fall protection to cross over the north-south wall form. Mr. Ibarra followed and tragically fell. This incident illustrates that work design can facilitate unsafe behaviour. It also shows how modeled behavior from supervisors may directly influence worker decisions, especially in the absence of clear guidance or intervention.

In several deaths, a Job Hazard Analysis ("JHA") to identify and control potential site-specific hazards was either not conducted or not communicated effectively to workers. In other deaths, communication regarding the JHA was restricted to the constructor's staff, with the expectation that employers would provide safety orientation to their own workers. Mr. Ismail Atas was the owner of an exterior stucco company subcontracted to apply styrofoam and stucco to a three-level retirement residence. He also acted as the supervisor while on site. The lot was located near a wooded area and adjacent to sloped, sandy terrain. The MLITSD heard from witnesses that Mr. Atas' company was provided with a site walkthrough and that sloping hazards in the sloped terrain were identified to subcontractors 20 days prior to the incident. However, apart from the site walkthrough, the constructor confirmed that they provided little oversight of subcontractors while on site. The constructor also verified that toolbox talks and the "daily 5," which identified hazards that the workers should anticipate, were reserved for the constructor's employees and were not shared with the subtrades. Mr. Atas had been working on site for two weeks when it came time to address the side of the house near the sloped terrain. They continued to use the telescopic boom lift that they had been using for other parts of the building for the two weeks prior. The boom lift manual stated that it should not

be operated unless on a firm, level surface. Shortly after moving the boom lift into place on the sloped area, it flipped over. Mr. Atas was trained on the boom lift and had working at heights training and Supervisor Health and Safety Training courses. Though the subtrades had been provided with a walkthrough, they were not involved in the constructor's daily morning talks, missing an opportunity for Mr. Atas and his team to have been reminded of the sloping terrain. which may have modified their approach by using an elevated platform.

Mr. Dmitrios Bouzalas was hired as a general labourer to assist an electrician in installing conduits for new electrical work. Mr. Bouzalas' co-worker described the site's safety culture as "relaxed." Basic safety practices, such as the consistent use of PPE, were reportedly overlooked. The site had no specific safety plan, and the safety coordinator had not visited the location. Compounding this, the constructor was in the process of transitioning to a new health and safety policy, and the constructor's staff appeared unfamiliar with the new processes. In this environment, Mr. Bouzalas, a part-time general labourer, was left to make his own decisions. In the course of performing general cleanup, Mr. Bouzalas found spare wire that he decided to store on the roof of the building. He used a ladder he found on the site to access the roof. There was a scissor lift on site, which the constructor stated would have been available for use, but which witnesses noted was unavailable to all but constructor staff. Mr. Bouzalas was not authorized to ascend to the roof and the ladder he found was in poor shape and not construction grade. Neither the constructor nor the employer were aware of Mr. Bouzalas' decision to access the roof and both were surprised he chose that course of action. Neither were consulted, but neither were effectively overseeing the work. Had there been effective safety measures and supervision on the site, Mr. Bouzalas may have made different choices.

Some constructors were unaware of the actions of subcontractors and their staff. Conversely, other constructors were proactive in highlighting the non-compliance of the sub-contractors, but did not follow up with disciplinary actions, even if action was mandated by their health and safety policies. In some cases, constructors offered no alternatives to the safety concerns and employees accepted those risks. Mr. Hernandez-Lopez was asked to wear a lanyard that the constructor apparently

knew made the work more difficult for shorter individuals. He may have uncoupled the lanyard to allow him to work faster.

In Mr. Steven Regular's death, the company identified the risks to the workers and continued forward with the job, despite multiple safety incidents. Mr. Regular was hired to remove and replace the existing flat roof on an industrial building. The employer had a comprehensive health and safety program, including detailed procedures for roofing and sheet metal work. The company's procedures emphasized situational awareness and marking hazards, but in practice, this translated to covering roof holes as they were discovered, rather than eliminating the hazard altogether. On the day of the incident, a roofing membrane had been removed, thus exposing old concrete decking that was unstable. Mr. Regular was pushing a wheelbarrow of debris toward the garbage chute positioned at the roof's edge, when the roof panel beneath him failed, causing him to fall approximately 17 feet to the ground below. A third-party engineering report prepared after the incident found that the concrete roofing decking was significantly deteriorated, and that no person should have been on the roof at the time of the incident. There had also been two near miss incidents documented prior to Mr. Regular's death concerning the exposed old concrete roof decking, although they did not result in injuries. One involved the wheels of a motorized cart breaking through the roof, and the other involved a worker's foot breaking through as they were walking. In response, the area was marked with a pylon and caution tape, and the possibility of a weak work area was discussed during a toolbox talk. The response to this hazard despite having two close calls suggests complacency with the work setting. Mr. Regular's fall through the roof occurred after recognition of issues that constituted a threat to worker safety and would be deemed unsafe by the constructor's health and safety manual.

These deaths collectively underscore the importance of not only having robust safety policies, but also ensuring they are communicated to all workplace parties on a project, including sub-contractors and their staff. More importantly, health and safety plans must be actively implemented and consistently enforced. Awareness of a hazard compels action. Not acting, as the deaths of Mr. Hernandez-Lopez and Mr. Regular demonstrate, can be fatal. Health and safety plans and programs must not

become abstract obligations with no real weight or consequence. Sadly, the absence of consequence is a theme that will emerge throughout this chapter. A culture of complacency can develop when risk becomes routine, and reversing this trend requires consistent engagement, accountability, and a shared commitment to safety.

Some workplace parties found themselves in a repeating cycle of violation and renewed compliance. Through inspections, the MLITSD identified violations and issued orders for compliance. The workplace parties complied with the MLITSD order, releasing them from possible sanctions, only to revert to previous practices. Mr. Connor Engelberts was 36 years old at the time of his death, with approximately 18 years of experience working at heights. Mr. Engelberts was widely regarded by both his employer and other workers as an expert in the construction of scaffolds. His reputation for exercising caution and maintaining precision earned him the title of “safest person” amongst his employer and co-workers. On the day of the incident, Mr. Engelberts and three workers were tasked with installing a metal roof on an attached garage. A scaffold was assembled on site; however, it was not planked appropriately, and lacked guardrails and an access ladder as required by the manufacturer’s instructions and Ontario Regulation 213/91 (Construction Projects). The improperly installed scaffold went unchanged despite an MLITSD compliance order 13 days prior that ordered that scaffolding at another site be brought into compliance. Tragically, as Mr. Engelberts was securing the metal roof panels, he approached the section that was planked incorrectly and fell to the ground below. The employer’s confidence in Mr. Engelberts’ abilities, in spite of a prior MLITSD order to correct the construction of the scaffolding, resulted in continued safety issues with apparent minimization of the risks of using improperly installed scaffolding.

Antonio Andre’s death was the result of an improperly built scaffold that the MLITSD and third-party consultants had identified as a hazard. Mr. Andre was a bricklayer contracted to provide brickwork on a housing development. The employer’s supervisor stated that he had worked with Mr. Andre for two years previously, but this was Mr. Andre’s first day on this job. Mr. Andre had arrived for work on the day of the incident and within minutes after ascending the scaffold his fall was heard by a

co-worker. Given the rapidity with which the incident occurred, he may not have been using fall protection equipment. Concerns about safety of the scaffolding were present. The MLITSD had issued multiple stop-work orders in the months leading up to his death, prompting temporary compliance sufficient to satisfy the concerns of the MLITSD inspectors. However, repetition and persistence of the issues over multiple visits suggests ineffectiveness or unwillingness in resolving the issue permanently. Two third-party site inspections were conducted two days prior to Mr. Andre's death by safety consultants hired by both the constructor and employer. Both inspections noted concerns on site with missing guardrails and other scaffold components. When asked if the scaffold had been inspected despite awareness of persistent and recurrent problems, the supervisor responded, "not really. It's all tarped in. I talked to the guys but didn't go in".

A culture of safety must be viewed not just as a formality, but as a critical component of every task performed on a construction site. Strengthening this culture requires a combination of education, supervision, accountability, and leadership at all levels of the workforce.

Absent, Untrained or Complacent Supervision

Ensuring that workplaces are safe for workers requires effective supervision and a comprehensive workplace safety strategy that considers potential hazards proactively. In many of the deaths reviewed by the Advisory Committee, the absence of on-site supervisors combined with insufficient or absent working at heights training emerged as a critical factor in the inability to identify and correct unsafe worker behaviour. Deaths may have been prevented through effective supervision with adequately trained supervisors to enforce working at heights safety standards and intervene where necessary.

Subsection 14 (1) of Ontario Regulation 213/91 (Construction Projects) requires a "constructor" to appoint a supervisor for every project at which five or more workers will work at the same time. Subsection 14 (2) states that a supervisor must supervise the work at all times either personally or by having an assistant, who is a competent person, do so personally. Similar requirements are laid out for "employers" in

section 15 of the Regulation.[4] A "competent person" is defined in the OHSA as a person who,

> (a) is qualified because of knowledge, training and experience to organize the work and its performance.
>
> (b) is familiar with this Act and the regulations that apply to the work.
>
> (c) has knowledge of any potential or actual danger to health or safety in the workplace.

There are circumstances in the deaths reviewed of absent or passive supervision from both constructors and employers on sites with more than five workers. In Mr. Poulton's death, seven workers were on the site, but a constructor supervisor was not present. When asked why there was no supervisor present the constructor indicated that he had no idea that Mr. Poulton's employer would be on the site that day. The employer indicated that normally he would have sent two workers to complete the job, but in the interest of expediency, sent seven. The employer's regular supervisor was on vacation and an acting supervisor was in charge. The acting supervisor was, therefore, overseeing an additional five workers. Under those circumstances, the acting supervisor expressed difficulties with monitoring all workers simultaneously.

The employer's policy mandated fall protection for working at heights at elevations of 10 feet or more. According to MLITSD measurements, the portable structures were approximately 3.26 metres (10 feet, seven inches) high, seven inches above the height the company deemed necessary for fall protection to be used. The acting supervisor felt that setting up guardrails would have taken unnecessary time especially since the height was so close to the threshold and the employer's project manager subsequently agreed to the foreman's decision not to install guardrails. Despite awareness that the roof was equipped with multiple anchor points, the crew was not wearing fall protection equipment. The acting supervisor thought the work would get started faster without putting the fall protection equipment on. The foreman's assumption was not challenged or corrected. Following Mr. Poulton's

[4] https://www.ontario.ca/laws/regulation/910213#BK6.

death, the company adjusted their internal requirements for fall protection gear from 10 feet to eight feet.

Mr. Andre's workplace was expected to have an average of up to 49 workers at the project, but his supervisor was not on-site at the time of the incident. In the days prior to the incident, safety concerns related to the scaffold were identified by the site supervisor and third-party safety consultants. The issues remained uncorrected and were not subject to follow-up inspection by a supervisor.

Similarly, multiple sub-contractors were on-site at the location where Mr. Bouzalas was working. Mr. Bouzalas' supervision by the constructor and his employer was reported to be intermittent, with witness statements indicating oversight occurred for only "a couple of hours a day". Although the employer was present on site on occasion, they were not working directly alongside workers to supervise the work being done. The lack of a supervisory presence and follow-up suggests missed opportunities to identify and mitigate hazards before incidents occurred.

Ms. Millsop was working on a project with six to 19 workers anticipated on-site, according to the Notice filed with the MLITSD. The constructor's supervisor was not present, apart from appearing intermittently to bring coffee, and was unaware that Ms. Millsop was providing assistance cleaning up debris. While he was an experienced carpenter, the constructor's supervisor lacked formal health and safety training, and appeared to be focussed on logistics and coordinating sub-trades, without involvement in the day-to-day demolition. Ms. Millsop was brought onto the site by the employee of a small company that worked small jobs infrequently. The company had just one worker, who had been in that position for about one month. Both the owner and the worker would engage friends and colleagues to assist with jobs on an as-needed basis. This is how Ms. Millsop ended up on the worksite: the worker and Ms. Millsop's partner knew each other socially through a campground and Ms. Millsop had used the connection to seek out work. The worker had offered her work via a text the night before the incident. He recognized that she was unqualified to assist with demolition and directed her and her partner to the basement to clean up debris. While on site, direction regarding health and safety was largely provided by Ms. Millsop's partner, who at one point had warned her about walking on the unsecured walkway. It is likely that the employee who offered

the work thought this was nothing more than assisting a friend without putting her or her partner at significant risk. But, as the worker was not a supervisor, and there was little interaction between them, it is difficult to characterize the relationship between the two as supervisory.

Mr. Antonio DaSilva, 60 years old, was living on government assistance and sought casual work to mitigate financial hardship. He found the job through a friend, who was also the constructor's employee, and was hired because the constructor thought he had experience in the construction industry. After a very brief conversation in the morning, the constructor, in addition to assigning general cleanup, had tasked him with climbing a ladder and cutting a hole in drywall, which he completed. He was given no training and was not wearing a hard hat or work boots. At the time of Mr. DaSilva's incident, no one knew where he was or what he was doing. Though he clearly fell from a ladder, when asked by the inspector, witnesses present at the site could not explain why Mr. DaSilva was on the ladder. It appears that Mr. DaSilva was keeping himself occupied in the absence of active supervision.

In addition to highlighting issues with supervision, both Ms. Millsop's and Mr. DaSilva's deaths underscore issues with hiring practices and the underground economy. Workers may seek informal work through smaller businesses that do not provide required training and oversight. Temporary workers are especially vulnerable to exploitation and unsafe working conditions, especially where employers do not provide supervision, general site awareness training or at times any training. These incidents underscore the need for stronger education to employers on their health and safety obligations and better public accountability in relation to hiring practices.

Two workers in our review, Mr. Engelberts and Mr. Wall, were working on projects of fewer than five workers and both were designated as supervisors. Witness statements collected during the MLITSD investigation of Mr. Engelberts' death indicate that he was well respected and trusted among those under his supervision. This trust may have dissuaded his co-workers from questioning his use of scaffolding that did not meet the regulatory standard. Despite a recent MLITSD

order relating to safety issues in the scaffolding at another site, that trust in Mr. Engelberts, both from his employer and his team, appeared to remain.

In review of Mr. Wall's death, evidence suggests that the constructor had a pattern of non-compliance regarding fall protection and general health and safety protocols. Prior and up to 2018, approximately two years before to Mr. Wall's death, the constructor had provided roofing installations using company staff. However, field visits by the MLITSD on two occasions in 2018 relating to the constructor had observed workers without fall protection or PPE. In that year, the constructor converted to a manufacturing/retail operation, outsourcing the installations to subcontractors, including Mr. Wall's company. Though the constructor developed a health and safety policy that mandated up to four warnings – the first verbal and the next three in writing – for failure to wear protective gear, they did not follow their policy. Mr. Wall's company was given multiple verbal warnings, but none were provided in writing. A termination notice was indicated after the fourth warning but was not provided to Mr. Wall's company. Supervisors have an obligation to model and enforce safe work practices. Complacent supervision contributes to the normalization of high-risk behaviours and undermines safety protocols, therefore putting everyone on site at a greater threat of injury and death.

Mr. Martin was the lone employee working under a supervisor. Though his employer tried at times, occasionally cautioning him that it was "better to be safe than sorry", he did not seek compliance with safety regulations. It may be that Mr. Martin's classification as an independent contractor, a self-employed individual who relies primarily on one client for income, left him, in the mind of the supervisor, outside of the employer's direct responsibility. This employment relationship may have influenced the employer's reluctance to intervene more assertively to ensure Mr. Martin's safety. Effective on-site management requires more than policies; it requires effective supervision, clear communication, and a culture that prioritizes safety through daily engagement. These deaths illustrate how gaps in these areas can potentially contribute to worker deaths.

Some of the deaths in this section occurred on sites that appear to have the characteristics of small projects despite having more than five workers present. Mr. Andre, Mr. Bouzalas and Ms. Millsop were all working as part of very small teams

away from other workers. Mr. Andre was alone on the scaffold; Mr. Bouzalas was working with a partner on the exterior of the building isolated from the other workers who were inside; and Ms. Millsop was working with a partner in the basement. In each of these three deaths, the constructor's supervisor did not effectively oversee the employer's teams or was unaware of their presence on the project. It may have been that, contrary to the OHSA and IRS, the constructor felt that the employer should be solely responsible for its own workers. The relationship between constructor and subtrades where health and safety are concerned is an area that would benefit from greater attention.

Mr. Engelberts, Mr. Wall and Mr. Martin were on small projects, but some of the same supervisory issues arose. With each annual review, we will continue to explore the health and safety challenges faced by workers in smaller companies or smaller subtrades on larger projects.

Fitness for Duty

Supervisors have a duty to take every reasonable precaution to protect the health and safety of workers. Along with the employer, this duty includes recognizing and responding to situations where a worker may not be fit for duty due to physical, psychological, or cognitive impairments that could compromise their ability to perform work safely. In some of the deaths under review, including Mr. A, Mr. Barrett, Mr. Martin, Mr. DaSilva, and Mr. Tjioe, investigations uncovered potential issues that could have had an impact on performance and might have contributed to the fall. Two workers reported feeling dizzy on the day of the incident. Several workers in the review were larger men, which may have made it more difficult to navigate the transition from a ladder to a roof or a ladder to a scaffold. In situations of significant risk, there are a number of factors that could have a detrimental effect on mobility, balance or stability.

Mr. Young Jun Na was a 71-year-old man hired by homeowners to replace a backyard patio roof. Mr. Na was the sole proprietor of a roofing company and, though retired four years prior to the incident, continued to take on renovation work. It was mid-October. Mr. Na was working into the early evening, assisted by the homeowner to lift metal panels onto the roof, approximately 8.5 feet in height. Mr.

Na was on the roof and the homeowner was on the ground lifting the panels. As Mr. Na was moving panels into place, he fell through an opening to the concrete floor below. At 71 years of age, Mr. Na may have been feeling the effects of the strenuous exertion, or he and the homeowner may have been keen to get the work done, potentially prioritizing expediency over safety precautions.

Mr. Emmanuel Ayettey, who co-owned a roofing company with his brothers, told them that he was not feeling well that day. They decided collectively that he would not access the roof for that reason. Keen to complete the job in one day, Mr. Ayettey accessed the roof using a ladder to help co-workers working on the roof install two temporary roof anchors. No one witnessed his fall, but the investigation revealed that the ladder he used was in good condition, and there was no clear equipment failure. Evidence suggested that proper procedures were being followed, including the installation of roof anchors for the assembly of a fall protection system to be used by workers on the roof for the roofing work. With other aspects of the job being performed safely, it is possible that illness on that day may have contributed to his fall.

Supervising ill or otherwise unfit workers can pose a difficult challenge. Managing those experiencing emotional struggles is much more complex. Mr. Jason Veenstra was a general labourer assisting with the installation of a metal roof deck on a project involving the construction of a large commercial building. Mr. Veenstra and another co-worker arrived at the site together and both used fall protection equipment throughout the day, including body harnesses and self-retracting lifelines. Witness interviews conducted by the MLITSD revealed that Mr. Veenstra appeared disengaged on the day of the incident and was reportedly stressed about a personal matter. Potential distraction may have resulted in Mr. Veenstra not connecting his fall protection to an anchor point shortly before his fall.

Expecting supervisors to identify and respond to physical and emotional stresses, whether illnesses or personal tribulations, may be unreasonable. As these deaths suggest, however, supervisors seeking to protect their workers may not only need to consider fall protection equipment and related strategies but may also need to be attuned to workers' physical, mental and emotional readiness.

Fragility of the Internal Responsibility System ("IRS")

The Internal Responsibility System ("IRS") is an important framework that helps ensure worker safety in the sector. However, the number of deaths in small and sole proprietor companies in our review suggests that the IRS may not be as effective in those types of work environments. As noted in chapter three, 16 of the companies employing the 26 workers whose deaths who are the subject of this review had fewer than 10 employees, 15 of them had under five employees and three were sole proprietor companies. In smaller companies, responsibility for health and safety practice falls heavily on the owner-operator. In addition to highlighting inconsistent application of health and safety requirements, a number of the 26 deaths in this review, in addition to those already outlined above, demonstrate a fragility or breakdown in the IRS.

The IRS only functions properly if all workers on a site are willing to embrace it. For example, Mr. Ambrosino was outside installing security cameras alone. Cabinet installers working inside the house heard his fall, but, unable to determine what caused the sound, did not to investigate. Mr. Ambrosino was lying in sub-zero temperatures until he was found approximately 40 minutes later. Had the sub-contractors inside been operating with the IRS in mind, they may have explored the source of the sound to assess for potential safety issues.

In addition, the IRS is only effective if workplace parties feel that they have a voice that will be heard and that appropriate action will be taken. Although Mr. Hernandez-Lopez was wearing a safety harness, his fall protection lanyard was not anchored at the time, reportedly because it may have restricted his movement. Mr. Hernandez-Lopez was noted by his co-workers to be operating unsafely, but they felt it was not their place to suggest correction in his behaviour. Conversely, about an hour prior to his death, his co-worker warned him to use his fall protection equipment, but Mr. Hernandez-Lopez persisted, and in response the supervisor took no disciplinary action.

The application of the IRS to sole proprietors is a challenging issue. Sole proprietor businesses leave safety to the discretion and judgment of one worker – the owner-operator – who for reasons of complacency or expediency may feel safe, even if

their safety is seriously at risk. Mr. Douglas, for example, was experienced and trained in the work being performed but chose not to use the fall protection because of the heat. He was working from the bucket of a bucket truck guiding heavy trusses from a crane hook into place on the roof of a barn. It may have been an action he had taken many times before. He may have been confident in his ability to perform the task. But this work would likely not have been permitted without using required fall protection equipment in a workplace with a strong safety culture and a functioning IRS.

This review reveals the consequences resulting from ineffective supervision in the protection of workers working at heights. This is especially apparent on small-scale projects, where the absence of a dedicated and competent supervisor can leave workers vulnerable to preventable hazards. Strengthening supervisory presence, quality and accountability, regardless of the size of the project, is essential to addressing this gap and ensuring that safety is not compromised in the pursuit of productivity.

Therefore, the OCC recommends the following:

RECOMMENDATION 2:

To the Provincial Labour Management Health and Safety Committee (as appointed under section 21 of the *Occupational Health and Safety Act*):

2. Explore options to enhance supervision on construction projects where workers are working at heights where there are fewer than five (5) workers.

3. Worker/Supervisor Education and Training:

Despite regulatory requirements and widespread training initiatives related to working at heights, deaths continue to occur, often under circumstances where risks were known and preventable. This underscores the need not only for continued training, but also for meaningful engagement that resonates with workers and reinforces the real-life consequences of unsafe practices.

Supervisors often serve as the first line of defense in identifying hazards, correcting unsafe behaviour, and fostering a culture of accountability. To fulfill this role

effectively, they must possess both the knowledge and the authority to act decisively in the interest of worker safety. Currently, employers are required to ensure that workers (which may include supervisors) who may use prescribed fall protection methods meet the working at heights training requirements. However, there is no specific regulatory requirement that a supervisor who may supervise a worker using a method of fall protection complete working at heights training if that supervisor does not use fall protection themselves. The circumstances surrounding several of the deaths reviewed highlight the potential implications of this and suggest a need to re-evaluate training expectations for those in supervisory roles.

Lack of Fall Protection and PPE

An important finding from chapter three is the frequent absence or improper use of fall protection equipment**.** In 22 of the 26 deaths under review, workers were not protected by any form of fall protection at the time of their falls; or, if fall protection equipment was present, it was either not properly secured (i.e., not tied off or connected to anchor point) or failed to function as intended due to equipment malfunctions. These findings point to challenges with both the implementation and oversight of fall protection protocols on certain construction sites. The pattern of absence of fall protection equipment suggests that either the systems were not made available, workers were not adequately trained or supervised in their use, or there was a broader cultural issue where fall protection was not prioritized.

It was specifically surprising in the review of the deaths of Mr. Hernandez-Lopez, Mr. Wall, Mr. Martins, and Mr. Engelberts, that fall protection choices were accepted by employers with limited pushback and without intervention. Employers suggested that fall protection should be used, but when those workers did not respond to these suggestions, the supervisors did not take additional steps to ensure that the workers followed through.

In reviewing the death of Mr. Ibarra, the supervisor modelled unsafe behaviour by disconnecting his fall protection and climbing over a wall. While Mr. Ibarra had a choice to act in a safer manner than his supervisor, the example set by his supervisor, especially if it was shown to be a quicker alternative, may have made the

safer approach seem unnecessary or impractical. Mr. Ibarra may have felt pressure to follow the example of his supervisor.

Absent or Inadequate Training

This review revealed deficiencies in both the content and delivery of health and safety training across multiple worksites. In several cases, there was no documented evidence that workers received adequate instruction on site-specific hazards, safe work procedures, or in the use of fall protection equipment. Where training had been provided, it was often limited to general awareness rather than tailored to the actual risks present in the specific work environment. There were no records of up-to-date general health and safety training or training specific to falls for Mr. A, Mr. Ambrosino, Mr. Bouzalas, Mr. DaSilva, Mr. Martin, Mr. Golshan, or Ms. Millsop.

Furthermore, there appeared to be a disconnect between constructors and trades that were working on-site. In some instances, constructors reserved site orientation, toolbox talks and daily check-ins to their own staff. Mr. Atas' company was not included in any of the "daily 5" discussions that pointed out potential risks on-site. Constructor staff were not always included in site orientation. Mr. Ibarra worked for the constructor but was generally employed at another worksite. He often split his time between two worksites. The constructor had mandatory site orientation training at the worksite in question that Mr. Ibarra did not attend. The constructor also held daily toolbox training sessions, but Mr. Ibarra did not participate. It is possible that because Mr. Ibarra split his time between two work locations, the constructor assumed that he understood the rules and requirements of both. Alternatively, he may have unfortunately been overlooked. There would likely be benefit gained from reviewing the relationship between constructors and sub-trades where it comes to ensuring that site orientations, safety responsibilities, and daily toolbox sessions are completed by all workers on-site.

Another area of potential concern is the availability of training in the languages spoken by the workers in this review. Several of the workers had first languages other than English. Mr. A (Turkish), Mr. Golshan (Farsi), Mr. Bouzalas (Greek), and Mr. Hernandez-Lopez (Spanish) did not speak English fluently. Had they received

training manuals in English, it is possible that they may not have understood the full content. In addition, unless oral instructions were delivered in their first languages, all four would have depended on their immediate supervisors or, in the death of Mr. Hernandez-Lopez, his colleagues, for translation, which may not have been feasible.

Finally, four workers, Mr. Andre, Ms. Millsop, Mr. DaSilva and Mr. Hernandez-Lopez, were on their first day at the work site, two of them with no experience in the construction sector. Three of the four began work without the benefit of working at heights training or a discussion of risks associated with their assigned work, and all four had little more than basic site orientations. Mr. Andre was entering a work area for the first time that had been deemed unsafe previously of which he may have been unaware. We have noted the dangers of leaving all workers unaware of site-specific risks or inexperienced workers unsupervised. The concern is compounded when they are also unaware of the risks on the site.

These issues suggest a gap between regulatory training requirements and the practical realities of construction work. The disconnect between constructors and sub-trades where training is concerned would benefit from additional understanding. It may also represent a broader issue regarding the role of supervisors at all levels (constructor and subtrade/employer). Our records indicate that only seven supervisors involved with the 26 deaths had documented working at heights training. In instances where the supervisor was not present at the time of the incident, it was difficult to confirm whether they had received this training, as such information was not consistently captured during MLITSD investigations. There are practical reasons for a site supervisor ensuring safe practice by all subtrades and an employer supervisor on site where people are working at heights to have training, including a basic understanding of when fall protection is required and how it works.

Equally as important, training informs an attitude toward the use of fall protection. Knowing the consequences of inaction in the face of a worker who repeatedly declines advice to use fall protection may encourage compliance. Knowing the consequences may help a company, like Mr. Poulton's employer, to reconsider the height at which fall protection is needed, even if that height is lower than the legal requirement. Effective health and safety training should go beyond minimum

standards: it should be interactive, scenario-based, and reinforced regularly. Supervisors benefit from understanding not only what the rules are and how to apply them in dynamic, high-risk settings, but also why they matter and what the consequences are for not applying them. Addressing training gaps will support a workforce that is both informed and empowered to make safe decisions on the job.

To address this issue, the OCC recommends the following:

RECOMMENDATION 3:

To the Ministry of Labour, Immigration, Training and Skills Development ("MLITSD"):

3. Consider amendment of O. Reg. 297/13 (Occupational Health and Safety Awareness and Training) to require working at heights training to be completed by a supervisor who may supervise a worker using a method of fall protection, to support the requirement that a supervisor be a "competent person" under the *Occupational Health and Safety Act*.

4. Homeowner and Small Business Education

Many of the deaths reviewed occurred in settings where the capacity for formal safety oversight may be limited, such as small business operations or residential projects initiated by homeowners. Fifteen of the deaths involved small business operations or sole proprietors. The death of Mr. Na demonstrates the challenges of health and safety implementation by sole proprietor businesses. Small business owners entering the construction sector may lack access to clear, accessible information about their obligations to comply with regulatory requirements and protect workers (including themselves, in the case of sole proprietors). Conversely, homeowners who have taken on the constructor role, often inadvertently, may not know that they have done so and may be unaware that they have legal responsibilities under the OHSA. The death of Mr. Tjioe illustrates the challenges homeowners face when taking on the role of constructor and upholding health and safety standards.

Constructors are legally responsible for ensuring health and safety on the project. But what if the constructor is a one-person operation? Who is responsible for

ensuring that health and safety training is up-to-date and completed? Additionally, who is responsible for ensuring that working conditions, hours, and physical exertions are within safe and reasonable parameters? Mr. Na was an experienced sole proprietor in the construction industry and was responsible for his own health and safety at the project. The homeowners were likely not aware – and were not required to be aware – that Mr. Na's working at heights training had expired. Additionally, the work refitting the patio roof was physically challenging, and Mr. Na was a 71-year-old man. Fatigue and poor work planning may have contributed to Mr. Na's death and may have been avoided if there was a clear understanding of the health and safety requirements and regulations on-site.

In some circumstances, the homeowner takes on the role of constructor. When this occurs, it is not always clear that they are aware of their obligations. The wife of the homeowner/constructor, who hired Mr. Tjioe raised concerns about the conditions in which Mr. Tjioe was working. Statements provided to the MLITSD revealed that she had expressed concern about Mr. Tjioe bringing the incorrect ladder to the job site and had offered to hold the ladder stable and act as a spotter, which Mr. Tjioe declined. The homeowner later stated that she had seen Mr. Tijoe at his car and assumed that he had left for the day but had not verified that this was the case. Unfortunately, Mr. Tjioe had not departed the project but had continued working and subsequently fell. At this point, the homeowner had left the site and did not return until the next day, after Mr. Tjioe was found deceased in the garage. Sadly, Mr. Tjioe was discovered by his family members early in the morning after they used a phone tracking app to locate him when he did not return home earlier that night. His work had progressed unsupervised and, because he fell when no one was present, he was unattended overnight. If someone had been there to assist or supervise – the constructor, in this instance – Mr. Tjioe may have benefited from medical attention.

Improving small business and homeowner awareness of their obligations when they take on the constructor role is important in the prevention of injuries and deaths. By equipping small business operators and homeowners with the right information when, for example, they are completing business registration, permit applications, or insurance processes, there is an opportunity to embed safety expectations before

work begins. This proactive approach may help reduce risk, clarify roles, and promote a culture of safety across all levels of construction activity.

The OCC recommends the following:

RECOMMENDATIONS 4 and 5:

To the Government of Ontario, the Ministry of Labour, Immigration, Training and Skills Development ("MLITSD"), the Ministry of Municipal Affairs and Housing ("MMAH"), the Ministry of Public and Business Service Delivery and Procurement ("MPBSDP"), the Ministry of Finance ("MOF"), the Ministry of Economic Development, Job Creation and Trade ("MEDJCT") and the Workplace Safety and Insurance Board ("WSIB"):

4. Led by the MLITSD and working collaboratively with the MMAH, the MPBSDP, the MOF, the MEDJCT, the WSIB and others determined as relevant, explore opportunities to develop and distribute clear and accessible information to:

    a. Support individuals registering and establishing a small construction business regarding their health and safety obligations, including those outlined under applicable legislation and regulations; and

    b. Help homeowners engaged in construction projects understand their health and safety obligations, including circumstances when homeowners may become constructors (as defined in legislation) for a project to allow them to make informed decisions.

5. Consider and devise a plan to best distribute the information referenced in this Recommendation through industry partners including, but not limited to, the Infrastructure Health and Safety Association ("IHSA"), home insurance companies, building permit providers and retail stores that sell building materials.

5. Case Studies in Training Courses:

All participants in the workplace should be empowered through training that is relatable, memorable, and grounded in real-world experiences. When workers understand the risks and can recognize the importance of safety protocols to their own lives and those of their peers, they are more likely to engage meaningfully with those practices. In response to a recommendation from the 2024 combined inquest into the deaths of William Bruin, Norman Gerrard and William (Dean) Maguire – three workers who died while working at heights at large construction projects - the IHSA released resources that include impactful stories from loved ones about the lives of Mr. Maguire[5] and Micheal Fisher.[6] This is a welcome approach that could be expanded into all working at heights training sessions. All but one of the deaths reviewed in this report involved multiple safety issues that ultimately contributed to the death of the worker. If shared with current workers, employers and constructors, the circumstances surrounding these deaths may prevent others from experiencing these circumstances.

Many of the materials available for review focus on the events surrounding the death of the individual. In some cases, the circumstances of the life of the person is clearly outlined and adds to the tragedy. For example, Mr. Hernandez-Lopez's life story is unlike the others in our review. Mr. Hernandez-Lopez was a 27-year-old authorized Temporary Foreign Worker from Veracruz, Mexico, where his family, including a daughter lived. He had been in Canada for two and a half years and had moved to Leamington to start a new life, which included dating a young farm worker. He had previously been a welder, but wanted to make a change, and saw potential in the work that he started doing on the day of his incident. He was excited to start (even though he had not yet been offered a position) and once on the job was eager to perform well. By all accounts, Mr. Hernandez-Lopez was an ambitious and eager worker who was seeking a better life in Ontario.

His death is instructive as it appears to have resulted from factors from four separate areas. First, the employer did not acquire, and the constructor did not properly

[5] https://www.ihsa.ca/IHSA-Health-Safety-Magazine/IHSAV242/Dean-Maguire-a-story-of-a-workplace-tragedy.aspx.
[6] https://www.ihsa.ca/pdfs/magazine/volume_13_Issue_1/Protecting_Young_Workers.pdf.

check, Mr. Hernandez-Lopez's employment credentials. Mr. Hernandez-Lopez was supposed to provide his employer his birth certificate and training qualifications on the morning he started, but the employer could not make it to the job site. Despite not having the appropriate documentation, the constructor accepted Mr. Hernandez-Lopez working at heights that day.

Second, one witness stated that Mr. Hernandez-Lopez, wanted to work fast, possibly in an effort to earn as much money by completing as many installations as quickly as possible. It is possible that in his haste he forgot to connect the lanyard or that he unhooked the mandatory safety equipment that may have been hindering the pace of his progress. Part of the issue was the equipment itself. The constructor's Health and Safety Representative noted that the safety lanyard Mr. Hernandez-Lopez was wearing made it difficult for shorter individuals to complete the tasks required. Mr. Hernandez-Lopez was 5'2" tall and his range of motion would likely have been impeded by the lanyard. While the limitations of the equipment were known to the constructor, Mr. Hernandez-Lopez did ascend to the platform.

Third, removal of the safety equipment was observed by his colleagues and supervisors, but despite attempts at intervention which Mr. Hernandez-Lopez dismissed, Mr. Hernandez-Lopez was permitted to continue working.

Finally, it was well known among the long serving employees that the panes of glass that Mr. Hernandez-Lopez was installing became brittle in the cold weather and that workers installing the glass should not lean on them. Witnesses stated that there were no safety instructions provided on the morning he died, though this information may have been conveyed outside of formal safety talks. Perhaps it was relayed and because his primary language was not English, the information was lost in translation. Perhaps the expectation was that one of his co-workers who shared his first language would provide that information. Nevertheless, in reaching to hammer in the plastic strips at the top of the pane of glass, Mr. Hernandez-Lopez leaned on the pane of glass, and it gave way.

At four stages in Mr. Hernandez-Lopez's few hours on his first day at a task that he should have been performing with fall protection, there were opportunities for intervention. Mr. Hernandez-Lopez's death provides a comprehensive and valuable

lessons which, if shared, could significantly impact those working in construction today and encourage health and safety compliance.

All of the 26 deaths in this report, and many of the deaths that have been examined in an inquest or in prior studies and reports by Threads of Life, the IHSA or the MLITSD, should be considered valuable for what they tell us about the importance of following health and safety regulations and engaging in safe work practices. We must also consider the lives of the workers who died and the impact of their deaths on the people who loved them. The work that Threads of Life and the IHSA are doing to bring those stories to the public is very meaningful and should be encouraged in as many venues as possible.

The OCC recommends the following:

RECOMMENDATION 6:

To the Chief Prevention Officer ("CPO"):

6. Consider developing and sharing communication with all Working at Heights training providers, encouraging them to incorporate real-life stories of workers who have experienced falls from heights workplace tragedies into their training. Two (2) examples can be found on the Infrastructure Health and Safety Association ("IHSA") website – Dean Maguire and Micheal Fisher.

Unforeseeable Risk

Unlike the other deaths in this review, Justin Schmidt's death was not the result of a foreseeable safety risk. Though an MLITSD investigation found minor infractions, his death was a result of a mechanical failure that was identified by a specialized, engineer repair service company under the direction of an MLITSD engineer.
Mr. Schmidt was a 19-year-old man who had returned from doing farm work in British Columbia to assist with the family business. He was operating an aerial work platform clearing tree branches that were impeding the constructor's heavy equipment. He had completed trimming branches and was preparing to lower the boom and bucket when it suddenly dropped 41 feet. The speed of the drop and the

force of the landing ejected Mr. Schmidt, who was then forcibly returned to the bucket by his fall protection harness and lanyard, causing multiple traumatic injuries. A preliminary examination by the MLITSD showed no reason for the sudden drop and a manufacturer's examination was also inconclusive. Only after the hydraulic system was disassembled by a specialist hydraulic service was it determined that a washer in the hydraulic cylinder was installed incorrectly, which was the cause of hydraulic failure and the drop. There is nothing that routine maintenance and testing could have discovered and there was nothing that workplace parties could have done differently to prevent Mr. Schmidt's death.

Funding

The Office of the Chief Coroner recognizes that the MLITSD, the IHSA and other participants are operating on limited budgets and that the recommendations within this report will require additional resources. To ensure that the recommendations are implementable, the OCC recommends the following:

RECOMMENDATION 7:

To the Government of Ontario:

7. Approve additional resources and/or funding to support the implementation of Recommendations #1-6.

Chapter 6: Family Testimonials

Gianluigi Ambrosino

My husband John was a wonderful father, husband, son, godfather to 5 wonderful kids, uncle and friend. He was very active. He would go to the gym 5 days a week and also played ball hockey.

He loved sports and was a die-hard Toronto Maple Leafs fan.

My daughter was a daddy's girl. He loved spending time with family and friends. He was so loved by many.

Thank you,

Wife of Gianluigi

Neil Despins

My name is Elizabeth Despins, mother to Neil Despins. I am writing this letter to give you the opportunity to know Neil on a personal level.

From the moment Neil arrived, he showed our family how strong his personality was. A very happy, headstrong little guy who had the energy of an energizer bunny. Always on the go. As Neil grew, he showed his determination to achieve whatever he set his mind on. Anything that caught Neil's attention, received all his attention.

In school, Neil played all sports offered, which helped harness that energy. Sitting in class was not easy for Neil. He was often disciplined for not sitting still in class. Fortunately, we were blessed to have had a teacher/coach who took Neil on to assist with junior high sports teams when needed. Whether it was getting equipment, scorekeeping, or helping with practices, Neil enjoyed doing what was asked of him. This also offered Neil the opportunity to excel in sports.
At the age of 18, Neil started his ironworking career. Starting off as a labourer, then gaining experience with welding, and then discovering his love for connecting. Neil made many friends in the industry, often relating to them as his work family. Our family was very proud to see how comfortable Neil was with his life.

Neil reconnected with his first love and her little guy. He loved the little one, as his own. Absolutely loving being a daddy. They soon welcomed a little girl and now their family was complete. At their wedding, the children were front and center with daddy and mommy.

So, he could be home with the family, Neil took on work that was local. This led him to working at the Arena, now known as Rogers Place. One of two lead connectors. In his element creating memories of a lifetime. Capturing on camera and reflecting on often.

At Neil's celebration of life, it made us (his dad, brother, and myself) very proud to hear the words used to describe our boy. Words such as mentor, authentic,

accountable, loyal, honest, and full of love. Our gentle giant. Go hard or go home and also live large were Neil's mottos.

Thank you for taking the time to review this letter. I hope this allows you to know Neil on a more personal level.

Liz Despins

I am writing this letter on behalf of my brother Neil Despins. My understanding is that the reason for this letter is to help understand Neil's character and who he was as a man.

I have had the opportunity to read the letters from his co-workers, and their words could not have rung more true. Neil was a dedicated co-worker and friend on the job site who would set everyone up for success whomever was working anywhere around him. I can attest to this because we worked in similar fields and would often end up on the same job sites. Neil's leadership, fun nature and drive passed through his co-workers. Which I still witness to this day when I work with his previous colleagues. I was proud to watch him as his brother to see how his fellow workers looked up to him and would do anything for him. They all relied on each other every day doing a very dangerous job, they would trust each other with each others lives day after day.

But I would like to touch on some of the things Neil was outside of work. Driven, dedicated and determined.

We were lucky enough to attend a very small K-9 school together. As a young energetic child, Neil often found himself not being able to sit still and pay attention in class. When Neil reached grade 4, our teacher/coach of the volleyball team asked me if I would mind having Neil attend our practices.

I agreed that it might be a good outlet for him in the middle of the day, so Neil started coming to practice with the junior high sports teams. He was naturally talented in athletics, so he learned very quickly with us. He would challenge himself to compete with the older teammates. Neil was determined to be just as good as the

rest of us. So, he would constantly be challenging me in whatever sport we would be playing throughout the school year. And these battles continued all the way through my college playing days. When we had open runs, he would attend, and Neil would keep up. He refused to lose.

When Neil met his son's mother, Austin would have been less than a year old. Neil almost immediately took on the role as his father and never looked back. Never was Austin looked at other than Neil's son. And when his daughter Isabelle was born, he said to me, "I have now completed the perfect family". I was privileged to be the person in the hospital with Neil when she was born, and I've never seen him so overjoyed. He was such a proud father.

Neil took everything in life full steam. Lived every moment to the fullest. His children meant the world to him. His family was what drove him to be the man he was.

Thank you for taking the time to read this long-winded letter about my brother.

Brendon Despins

I would first like to introduce myself. My name is Matthew Grenier. I am a journeyman ironworker currently in a general foreman position. I hold this position for a heavy industrial and oil and gas construction and maintenance company. I have worked in many aspects of the trade since starting in 2012.

But I am writing to talk about someone who greatly impacted my growth, both professionally and personally. This person is Neil Despins. I first met Neil on my first day on what was known at that time as the Edmonton Arena project, later named Rogers Place. To most of us who worked on the project, it is simply known as "the arena". I already knew someone who was working on the project, and he showed me around and introduced me to some of the guys on the crew, one of those guys was Neil. I received a strong handshake and a "Nice to meet you, partner" that filled the room. Neil set the energy in whatever room he was in, that energy was always happy, playful, and full of jokes. At this time, I was a few years younger than Neil and had many fewer years in the industry. Neil's dad Malcolm was an ironworker and passed a lot of knowledge on to Neil which showed because Neil knew what he was doing.

This was something I noticed right away. Neil and I were both big guys, and seeing how he moved around on the steel showed me that someone my size could be successful in the industry.

After a month or two I was moved from the detail crew to the erection crew, and I was able to work with the connectors a lot. I told them all that it would be a dream to be able to say that I was a connector on the arena that would house my favorite team. A few weeks later Neil would say he was a little sore, he told the foreman that he didn't want to go up that day. Neil and his connecting partner Marc told the foreman that it was my turn to go up. The two of them made my dream come true.

I feel like this story shows what Neil was like as a person and as an ironworker. Neil knew what he was doing, he never had to prove it to anyone. Neil also knew that with his grand personality people saw him, they knew who he was, and he knew that the young guys coming up would naturally look at him and want to learn from him. I was one of those young guys. After the project ended, I went on to spend some time working in a mod yard but stayed in contact with a group of guys from the arena one of which was Neil. After leaving the mod yard I ended up back with Neil and a few other guys working commercial around western Canada. Neil and I were connecting partners for a lot of the 3 years I worked for that company. We went from job to job and connected together.

For people outside of the industry, it is hard to imagine the bond that guys can have when working in an environment like this. Neil and I spent a lot of time together both at work and because we were away from our families, we spent a lot of time together after work. At some points at work, we would have our lives in each other's hands. Neil became like a brother.

Through this time, I witnessed Neil have the same effect on others as he did on me when we first met. That constant ability to make those around him better and safer at the job. Especially on those out-of-town jobs, Neil breeds a sense of family in the crew. He would bring everyone together, make sure that the younger guys came out for dinner with the older guys, even picking up their tabs knowing that they didn't make as much as the others yet.

After a few years, Neil and I weren't working together as much but we still stayed in contact. Sometimes during long drives between jobs, we would call each other up just to check in and see how the other projects were going and make sure everyone was playing safe. I still do this with a lot of my friends in the trade. I later left the company to pursue my own professional goals but never lost contact with Neil.

Neil's death has affected many people who work in the industry and will continue to affect many people. As I stated before I am a supervisor now thanks a lot to the things Neil taught me early in my career. His story will be passed through me to many crews for years to come.

In closing, I would simply like to say that my brother Neil Despins, at work was one of the safest, smartest, hardest-working ironworkers I ever had the pleasure of working with. Outside of work, he was one of the funniest, loudest, most caring, kindest, most loving human beings I have ever known. And I miss my friend very much.

Hello, my name is Marc Roth and I am going to tell you about my friend Neil Despins. I first met Neil around 2011 in Elkford B.C. while working with Whitemud Ironworks. I really got to know Neil very well at this job. The dude wouldn't shut up, he definitely had the gift of the gab. But a very hard worker with a huge heart. Me and Neil became very good friends at work and out of work, we worked on numerous projects. I couldn't even tell you how many. Neil showed up every day for work. I can't recall the last time he actually took a sick day. He was definitely a character, always making everyone laugh. He often went out of his way to get to know all his co-workers. Kind of make sure everyone was getting along and working together, making everyone feel included. He had that effect on a large crowd. Not only with his excellent attitude at work, he was a very hard worker. He was very safe at work, always keeping an eye on himself and everyone else. He can pretty much do it all when it comes to Ironworking and welding. He was an excellent connector. Me and Neil connected steel more than anything when I worked with him. At one point me and Neil spent a full year connecting steel at the Rogers Place arena. That's a long time together. Me and Neil made a great team. I'm 5' 6'' ish on my best days and he was an absolute monster. I would get into the hard to reach spots and Neil was

straight brute force. He always talked about his family who he dearly loved more than anything. His kids, his parents and siblings. I often think about Neil after the accident. I remember all the good times. He left us all with the best memories. He was an absolute animal with the biggest heart.

Tracey Millsop

Tracey Millsop's, mother, Carolyn Millsop, provided remembrances of Ms. Millsop "to show her family and what we are all missing due to her untimely death".

These included remembrances from Christmas, of time spent with her parents and her children, her daughter's high school graduation, time with her sister Kim, and her final resting place. These memories were shared with the Advisory Committee.

In addition, Carolyn Millsop provided these words: Tracey enjoyed helping out at her son's school. Tracey is missing out on seeing her children grow up, get married and the possibility of becoming a grandmother.

James Oosterhuis

Provided by Brenda Becker, Mr. Oosterhuis's wife:

James had the biggest heart, and he was the hardest-working guy you could imagine. He faced many challenges throughout his life but continued forward with bullish optimism and ceaseless tenacity. James always showed up with a zany comment, crazy joke, random story, or a unique observation. He was known for his compassion and willingness to jump in to help when he saw a need or to fix whatever was broken. He is missed profoundly by all who knew him.

Russell (Scott) Poulton

You didn't know my step-father. You have heard what happened to him, but without knowing who he was, how could you truly understand what my family has lost? He's not the kind of person that can be summed up in a few words. Scott loved to joke and laugh, but he was a man of action, not words. Regardless, I'll do my best with words to tell you about who he was, and the impact his death has had on our family.

Let me begin by introducing myself. My name is Karly, and I had the privilege of being Scott's step-daughter. Not that Scott saw it that way, he called me "daughter" all the time. In his eyes, I was his too, even when I didn't make it easy on him. It didn't matter. He saw me, labeled me, and treated me as his. If Scott cared about you, you knew it. You knew it deep in your bones, he would make sure of it.

When my mom met Scott, right away that was it for them. They just knew what kind of love they had found. They got engaged after two months of dating. They fit together. My mom has a heart so big I never thought she could find it's equal, but she did. They were each other's forever. He called her Honey and she called him Little Scooty. They should have been each other's forever.

Scott had a wife he adored and she adored him right back. He had four children, three step-children, four daughters and sons-in-law, and seven grandchildren. On any given weekend you would find him driving all over southern Ontario, from London, to Owen Sound, to Toronto, either visiting or offering to help anyone and everyone with whatever they needed. From coming to boost my car when my battery died to helping my uncle build a chicken coop. If you needed anything, he would be there without even being asked. He was the one we all relied on, the one we would call if we needed help. When my kitchen drawer broke, when I didn't know what kind of coolant I needed for my car, Scott would always know what to do.

He was there for us in a way that made me truly believe he would always be there, that I'd always have him to depend on. But that's not the case. He's not here, and

now we have this huge hole in the center of our family, a void that's felt every day. He's not here. Even after watching him die with my own eyes, I still catch myself forgetting sometimes because it's just so hard to believe and accept. He's not here.

That was the hardest thing I've ever had to do, just stand there and watch helplessly as he left our family. Standing shoulder to shoulder in the hospital room, watching the man that had been there for us every day, the one with the loudest laugh and the biggest heart, fade away as the colour slowly drained from his face. That's the image that will live with me forever, the movie that will always play in my head. All I have to do is close my eyes and I'm back in that hospital room.

As the machines were turned off, I stood there motionless, looking across the bed at my mother as she held his hand, stroking it gently until it went cold. Seeing my step siblings out of the corner of my eye, his children surrounding him. Unable to meet their gaze as our faces streamed. It felt like I had cried enough to fill a lake but somehow the tears didn't stop. Not for hours, not for days.

I can't tell you how long we stood silently in that room after he died. It felt like a lifetime. We couldn't move, couldn't bear to leave him there. It felt like if we just stood there beside him a little longer maybe his eyes would still open, maybe it wouldn't be real. I couldn't tolerate the thought of going home without him. The whole week we were in the hospital, I never really thought Scott wouldn't be coming home with us. Even after days of him being unconscious and on life support, I just couldn't imagine life without Scott. How could we leave there without him?

How could my mother go on without her husband? How could we lose our father? It was unimaginable. But it did happen. And all we could do was stand together and watch. I've been watching ever since.

In the weeks after Scott died, I was watching as my mother sobbed herself to sleep. Then, even worse, watching her wake up peacefully knowing that in about 10 seconds she would turn to see me laying beside her instead of Scott and she would remember what happened. Watching her fall apart all over again, every morning. Watching her eyes change as the pain set in, the pain that lives there every day. It's taken up residence within her irises, part of her now.

For months I found myself unconsciously watching for him. Looking up when I heard a noise in the kitchen because my first thought was always that Scott had come up for another coffee. But no matter how long I stare at the coffee maker in the corner, he's never there. My brain unwilling or unable to comprehend that he had gone to work one day and never came home again. Even now, a year and a half later, my eyes are still watching. They are constantly drawn to the traces of him that remain, to the places he should be. To his empty spot on the couch, his hat still hanging up, the rings my mother wears. I see them all.

I continue to watch how my family has changed. My mother hasn't returned to her normal life, she's not the same person she was. She's lost her vibrancy, almost like she used to be in colour but now she lives in black and white. She's quieter, subdued, more cautious, and fragile. The smallest things will bring her to tears. Things she used to love are now things she can no longer do. She used to be a reader, but she hasn't read a book since. Her brain now incapable of focusing on the words on the page. She has been unable to go back to work, unable to handle the people as she's haunted by rude comments and questions about how Scott died. The grief she carries is all-consuming, and unending. All of our grief is unending. His three youngest grandchildren weren't even a year old when he died, they all just turned two within the past two months. They are running around now and talking. They won't be given one of his strange nicknames or get to hear his quick, infectious laugh as they play. They won't have him cheering them on at every one of their sports games or be able to call him when their car breaks down like his children did. They will never understand what a wonderful man their grandfather was, for he loved so deeply through actions they will never see. He was taken from them.

As hard as it was and still is, I can't look away. I can never stop watching. Life without him keeps going, and the spaces he should be filling get bigger not smaller as he misses more and more things. More family events, more changes. Things he should have celebrated with us, things he would have helped us through. Everything is quieter now without the sound of his loud voice, his quick laugh. He's not here for any of it.

How can you quantify the impact of watching your family be devastated? How can you convey the level of pain you have all lived with since, or measure the emptiness

you feel at his loss? You can't. I can't. Nothing can prepare you for having someone so dear to you go to work one morning, like he did every morning, and never come home. Everyday, mundane actions like going to work aren't supposed to be unsafe. We didn't know to fear it before, but now we do.

The security we had in our normal life has been shattered. The damage to me, to our family, all the people that knew and loved Scott, the countless people he had cared for deeply and called by his ridiculous nicknames, the countless people he would drop everything to help, the damage done to us is irreversible. We carry the grief with us every day. And as hard as it was and still is,

I can't look away as life goes on without him. I can't unsee the effect on my mother and our family. I will see it every day for the rest of my life.

Michael Wheeler

In honour of my husband, and our children's father, Mike.

I can't tell you how hard Mike worked since he was a little boy. Mike was born in Stephenville, Newfoundland on the U.S. Airforce base. His father was an American and his mother was a Canadian (born in Newfoundland). Mike grew up with his mom's very large family and his brothers and sisters in Newfoundland.

No words will ever be enough to express our loss due to the tragic tragedy (Catastrophic) of this Great person (and Mike and I will tell you we are not easily impressed).

Mr. Mike (Michael) DeForest Wheeler to say the least was an honest, very hard working, dedicated, (a go getter), ambitious, a great sense of humour and very proud man, husband, father, etc. and a very proud gas technician fitter Level 1. (Which for the record he obtained much later in his life (approx. 40 yrs. old)).

Very proud to have a trade as a gas fitter!

Mike was always the life of any room he entered, he was the type of person that would start a conversation with you in a grocery store line up, gas station, he even made the Custom Personnel at the U.S. border laugh, etc.…

Mike was a great best friend to many including me, a brother, son-in-law, brother-in-law, uncle, etc. and a colleague (he always had an ear to listen to concerns of others) (and tried to help whenever he could).

Mike was the guy that called to say "hi" and didn't need anything!

Mike could fix anything mechanical including cook a great meal!

We miss Mike tremendously!

And so does his new family that we discovered when Mike obtained his U.S. passport in 2019 along with his 3 siblings from his father's side. Mike was so excited to spend time and make new memories with them!

I can tell you as his wife and friend of 34 years that Mike was very very proud of his work and to have a trade and call himself a gas fitter and if it wasn't good enough for him and his family in his home, he wouldn't compromise it in someone else's.

It is a damn shame for Mike's life work not to be able to enjoy retirement and enjoy all he worked for….

I truly wish you could have met him.

His wife, friend, mother of our children, etc.

Kelly

Mrs. Kelly Wheeler

Appendix A: Terms of Reference

1. Purpose and Objectives of the Construction Death Review

a) The purpose of the Construction Death Review ("CDR") is to review all worker deaths resulting from an accident that occurred in the course of their employment while at, on, or in a construction project.

b) Worker deaths will be examined at the individual, group, and systemic levels to develop recommendations for preventing further deaths in the construction sector.

c) The review will be directed by a coroner or group of coroners appointed by the Chief Coroner and advised and supported by a diverse team of representatives and experts from government and industry.

d) The results of the review will be submitted as a report to the Chief Coroner and made available to the public.

e) The CDR will be conducted in a timely manner and in accordance with the requirements of the *Coroners Act*.

2. Scope of the CDR

a) The scope of the CDR is set out at subsection 10.2 (4) of the *Coroners Act*:

> **Scope of Review**
>
> 10.2 (4) A coroner or team of coroners conducting a review under this section shall:
>
> (a) examine the circumstances of each of the deaths subject to their review;
> (b) to the extent possible, conduct a systemic examination of the circumstances of all of the deaths subject to their review and, if the coroner or team of coroners consider it appropriate, related deaths that are not subject to their review;
> (c) to the extent possible, identify any common issues among the deaths that are subject to their review; and
> (d) develop recommendations for the prevention of further deaths.

3. CDR Participants

1) Overview

a) Lead Coroner(s) appointed by the Chief Coroner will direct the CDR.

b) An Advisory Committee appointed by the Chief Coroner will advise the Lead Coroner(s).

c) The Lead Coroner(s) and the Advisory Committee will be supported by the Secretariat, which provides logistic, policy, legal and investigative assistance.

d) Subcommittees recommended by the Advisory Committee or Secretariat and approved by the Chief Coroner may be convened where necessary.

2) Composition and Selection

a) Lead Coroner(s)

i. The Lead Coroner(s) will be appointed by the Chief Coroner.

b) Secretariat

i. The CDR Secretariat will consist of staff from the Office of the Chief Coroner (OCC), including:

A. Manager, CDR;
B. Executive Lead;
C. Senior Policy Advisor/ Deputy Executive Lead;
D. Legal Counsel;
E. Investigator; and
F. Program Administrator.

c) Advisory Committee

i. The Advisory Committee will consist of eleven (11) permanent members, approved by the Chief Coroner, with diverse representation from the OCC and construction sector stakeholders, including:

A. One (1) OCC member (Manager, CDR);

B. Two (2) Ministry of Labour, Immigration, Training and Skills Development (MLITSD) members (Prevention Division and Fair, Safe and Healthy Workplaces Division representatives);

C. Three (3) Construction Labour Organization members, recommended by the Provincial Building and Construction Trades

Council of Ontario, with at least one (1) affiliated with the Provincial Labour Management Health and Safety Committee (PLMHSC);

D. Three (3) Construction Ownership Organization members, recommended by the Infrastructure Health and Safety Association (IHSA), with at least one (1) affiliated with the PLMHSC; and

E. Two (2) Health and Safety Organization members (IHSA representative and Workplace Safety and Insurance Board representative).

F. In addition, one (1) representative from Threads of Life will have a standing invitation to provide expertise on issues relating to families impacted by construction-sector deaths.

ii. When conducting business of the CDR, the Advisory Committee can only meet with the Lead Coroner(s) in attendance and acting as Chair.

iii. Permanent members must meet one or more of the following selection criteria:

A. Has, in their professional capacity, a provincial understanding of and primary focus on the construction sector and its practices; and/or

B. Has access to skills and knowledge that permit the ability to make recommendations on a broad range of issues, ranging from practical to theoretical; and/or

C. Has an understanding of the existing Health and Safety regime in the province.

iv. The selection process for permanent members is as follows:

A. An authorized organization recommends candidate(s) to OCC with a description of their skills, experience and qualifications; and

B. The Chief Coroner reviews candidates and appoints permanent members based on the above-noted selection criteria.

I. For the purposes of the CDR, “authorized organization” is defined as one of the following: the MLITSD, the Provincial Building and Construction Trades Council of Ontario, the

IHSA, the Workplace Safety and Insurance Board and Threads of Life.

v. Membership on the Advisory Committee will be for terms of up to three (3) years, renewable.

vi. Individuals serving as permanent members may be substituted if the member is no longer available/able to serve or as the relevant organization sees fit, pending approval by the Chief Coroner.

vii. Where required by workload or caseload, temporary memberships may be created and assigned, based on the above-noted selection criteria and process for permanent members. Where temporary members are assigned, consideration will be given to ensuring diverse representation from the construction sector and stakeholders, as with the Advisory Committee.

viii. The conduct and provision of services by each member on the committee will be governed by a CDR Member Letter of Agreement. The Letter of Agreement will include, for example, provisions related to privacy, confidentiality, and conflicts of interest.

ix. At the discretion of the Chief Coroner, members who violate the Letter of Agreement or the Terms of Reference will be removed by the Chief Coroner.

x. Members may resign from the Advisory Committee, with notice to the Chief Coroner, the Lead Coroner(s) and their respective authorized organization.

d) Subcommittees

i. Subcommittees will consist of subject-matter experts who are identified by the Secretariat or Advisory Committee and whose participation is determined by the Lead Coroner(s) as necessary to conduct a comprehensive review.

ii. Lead Coroner(s) may consult with Secretariat or Advisory Committee on purpose, scope and members of Subcommittee.

iii. Where the Lead Coroner(s) determine that a Subcommittee is necessary and identifies appropriate members, they will seek approval from the Chief Coroner.

iv. The Chief Coroner has discretion to approve the formation of a Subcommittee as proposed or with modifications, or to refuse the formation of a Subcommittee.

v. In considering whether a Subcommittee is necessary, the following factors may be considered:

    A. Workload or caseload;

    B. Whether the circumstances of a death or group of deaths involve specific issues requiring specialized expertise. Areas of expertise include, but are not limited to:

        I. Systemic issues, including social determinants of health;
        II. Technical issues; and
        III. Cultural knowledge (e.g., Indigenous Knowledge Keepers and Elders).

vi. The selection process for Subcommittees and their members is as follows:

    A. Secretariat or Advisory Committee identifies necessity for Subcommittee.

    B. Secretariat or Advisory Committee recommends Subcommittee to the Lead Coroner(s), in writing. In doing so, the Secretariat or Advisory Committee will identify the following:

        I. Purpose and scope of Subcommittee; and
        II. Appropriate members of Subcommittee.

3) Roles and Responsibilities

a) Lead Coroner(s)

i. The Role of the Lead Coroner(s) is to direct annual reviews of construction deaths and report on these reviews to the Chief Coroner.

ii. The Lead Coroner(s) have the following responsibilities:

A. Convene and chair Advisory Committee meetings;

B. Review briefs and other relevant documents; and assign briefs in consultation with the Secretariat;

C. Review Case Review Templates (CRTs) completed by Advisory Committee;

D. Determine, in consultation with the Chief Coroner, whether Subcommittee(s) are necessary;

E. Consult with Advisory Committee members on:

I. Examination of circumstances of each worker death;
II. Identification of systemic issues; and
III. Development of recommendations.

F. Consult with the Secretariat on:

I. Examination of circumstances of each worker death;
II. Identification of groups of deaths or systemic issues;
III. Development of recommendations; and
IV. Logistic issues related to the CDR, the Advisory Committee and any Subcommittees.

G. Prepare report(s) on annual reviews with assistance from the Secretariat;

H. Consult with and report to the Chief Coroner as required; and

I. Any other duties determined by the Chief Coroner.

b) Secretariat

i. The role of the Secretariat is to ensure that the CDR operates in accordance with section 10.2 of the *Coroners Act*.

ii. The Secretariat reports to the Manager, CDR.

iii. The Secretariat has the following responsibilities:

A. Manager, CDR

I. Ensure that all CDR processes and conduct meet Ontario Public Service (OPS) policies and standards;
II. Oversee the overall functioning of the CDR;
III. Assist Lead Coroner(s) in preparation of annual report(s); and
IV. Any other duties determined by the Chief Coroner.

B. Executive Lead

I. Oversee day-to-day logistics of CDR, including scheduling meetings, preparing meeting agendas and maintaining meeting-minutes;
II. Act as main point of contact for Lead Coroner(s), Advisory Committee members and Subcommittee members;
III. Act as main point of contact for the MLITSD and other stakeholders on CDR-related items;
IV. Track and maintain list of annual deaths in consultation with the MLITSD, to be shared with the Chief Coroner;
V. Track and maintain caseload information, including in respect of deferrals;
VI. Review briefs and assist Senior Policy Advisor in the preparation of preliminary summaries;
VII. Consult with Secretariat on whether Subcommittees are necessary and, if so, recommend Subcommittees to Lead Coroner(s); and
VIII. Any other duties determined by the Manager, CDR to be necessary to the functioning of the CDR.

C. Senior Policy Advisor/ Deputy Executive Lead
    I. In the absence of the Executive Lead, the Senior Policy Advisor assumes the role and responsibilities of the Executive Lead;
    II. Review materials and prepare preliminary summaries;
    III. Assist Lead Coroner(s) in preparation of annual report(s);
    IV. Advise on policy issues;
    V. Research and analyze systemic and other issues as required; and
    VI. Any other duties determined by the Manager, CDR to be necessary to the functioning of the CDR.

D. Legal Counsel
    I. Advise on legal issues;
    II. Ensure that CDR process and documents meet applicable legal requirements;
    III. Act as point of contact with legal representatives from other Ministry, sectoral or external entities;
    IV. Review briefs and preliminary summaries;
    V. Review and advise on report(s); and
    VI. Any other duties determined by the Manager, CDR and Chief Counsel, Office of the Chief Coroner, in consultation.

E. Investigator
    I. Contact and consult with family members or personal representatives of the deceased person;
    II. Prepare briefs and distribute them to Lead Coroner(s) and Advisory Committee;
    III. Conduct additional investigation where necessary; and
    IV. Any other duties determined by the Manager, CDR to be necessary to the functioning of the CDR.

F. Program Administrator
    I. Assist Executive Lead in tracking annual death and caseload information;

II. Maintain internal database of CDR correspondence and documents, including investigative materials;
III. Assist Investigator with preparing briefs; and
IV. Any other duties determined by the Manager, CDR to be necessary to the functioning of the CDR.

c) Advisory Committee

i. The role of the Advisory Committee is to advise Lead Coroner(s) on annual reviews of construction deaths.

ii. The Advisory Committee has the following duties:

A. Attend meetings convened by Lead Coroner(s);
B. Review assigned briefs and preliminary summaries;
C. Consult on whether Subcommittees are necessary and, if so, recommend Subcommittee groupings to Lead Coroner(s);
D. Examine circumstances of each worker death and complete Case Review Templates (CRTs);
E. Identify systemic issues;
F. Develop recommendations for consideration of Lead Coroner(s);
G. Adhere to the terms and conditions in member Letters of Agreement and this Terms of Reference; and
H. Any other duties in support of the CDR determined by the Chief Coroner.

d) Subcommittees

i. The role of a Subcommittee is to provide specialized expertise on one or more specific issue(s) identified by the Lead Coroner(s), Secretariat or Advisory Committee in annual reviews of construction deaths.

ii. The Subcommittee may assist the Advisory Committee and/or Lead Coroner(s) in the following ways:

A. By conducting a given review;
B. By consulting on issues and providing expert assistance as requested by the Lead Coroner(s); and/or

C. Any other duties in support of the CDR determined by the Chief Coroner.

e) Additional Investigation: Scope and Limits

i. The Lead Coroner(s) and / or the Investigator are the **only** CDR participants authorized to conduct additional investigation for the purposes of the CDR. This includes collecting evidence and/or contacting involved parties, witnesses or family members who may have information relevant to the review.

4) Approach to Recommendations and Dispute Resolution

a) Recommendations will be developed through a collaborative process. The Advisory Committee will consult on recommendations, with the support of a Subcommittee or those with specialized expertise, if required. The Advisory Committee will then advise the Lead Coroner(s) on proposed recommendations.

i. The Advisory Committee will identify recommendations that are jointly proposed by all members. For recommendations that are not jointly proposed, the Advisory Committee will identify which members support the recommendation, do not support the recommendation, or take no position on the recommendation, where applicable.

ii. Where a recommendation is not jointly proposed, the Lead Coroner(s) may consult with the Advisory Committee members on their respective positions and request written submissions, if necessary.

b) The Lead Coroner(s) conducting the review process has/have statutory authority to develop and report on recommendations. For example:

i. A recommendation will be included in the report if the Lead Coroner(s), in consultation with the Chief Coroner, determine that the recommendation is appropriate, actionable and/ or contributes to the prevention of further deaths, regardless of whether or not the recommendation is jointly proposed by the Advisory Committee.

ii. A recommendation will not be included in the report if the Lead Coroner(s), in consultation with the Chief Coroner, determine that the recommendation is not appropriate, actionable and/ or does not contribute to the prevention of further deaths, regardless of whether or not the recommendation is jointly proposed by the Advisory Committee.

c) The Lead Coroner(s), in consultation with the Chief Coroner, may include recommendations not proposed by the Advisory Committee but determined to be appropriate, actionable and preventative based on their findings in the review process.

d) Responses to the previous year's recommendations should be included in each annual report and shared through the OCC open data submission.

4. The CDR Review Process

1) Overview

a) The CDR runs on a three (3)-year cycle which includes the year in which the death occurs, the year in which a review is commenced, and the year in which a report is released:

i. Year 1: Year of Death;
ii. Year 2: Year of Review; and
iii. Year 3: Year of Report.

b) The CDR will be conducted in a timely manner, in accordance with the requirements under subsections 10.2 (1) and (11) of the *Coroners Act*.

2) Year 1: Year of Death

a) The Secretariat will develop a list of annual deaths in consultation with MLITSD, to be shared with the Chief Coroner.

b) The Chief Coroner will determine the deaths to proceed to review in the following calendar year.

c) Under the direction of the Lead Coroner(s), the CDR's Investigator will collect all relevant material for each death being reviewed in a calendar year and will compile such materials in an electronic format. These

materials will eventually be compiled into electronic briefs. Briefs may include:

i. Materials collected during a Coroner's investigation;
ii. Materials collected by other investigative agencies, including the MLITSD and regional police forces;
iii. Any other materials deemed relevant by the Lead Coroner(s) and/or Investigator.

d) Members of the Secretariat will review the materials and will prepare a preliminary summary for each death.

e) The Lead Coroner(s) will review all the preliminary summaries and identify potential groupings in consultation with the Secretariat. Groupings are subject to the approval of the Chief Coroner.

3) Year 2: Year of Review

a) In January of each review year, briefs will be assigned and distributed to Advisory Committee members by the Secretariat. Each death will be assigned to and reviewed by at least two (2) members of the Advisory Committee. This will help to ensure that there is a diversity of expertise and perspectives informing each review.

b) Advisory Committee members will review their assigned briefs and complete a Case Review Template (CRT) for each death, summarizing their findings and opinions. The Secretariat may provide support with the completion of the CRT, if required. Completed CRTs will be provided to the Secretariat.

c) The CRT will be developed by the Secretariat and may include, for example:

i. Synopses of circumstances of the individual deaths being reviewed, including who the deceased was, when the deceased came to their death, where the deceased came to their death, how the deceased came to their death, and by what means the deceased came to their death;
ii. Relevant legislation and/or regulations that may be engaged;

iii. Whether the review requires any additional information or additional consideration by those with specialized knowledge or expertise; and
iv. Any proposed recommendations.

d) The Advisory Committee will meet with the Lead Coroner(s) and members of the Secretariat. During this meeting, presided over by the Lead Coroner(s) members will present their respective case(s). Completed CRTs will be shared with the Committee and reviewed in advance of the meeting.

e) The Advisory Committee will discuss the reviewed deaths and advise the Lead Coroner(s) in relation to potential recommendations arising from the deaths. This may include both case-specific recommendations and systemic recommendations arising from groups of deaths.

f) The Advisory Committee will not make any findings of legal responsibility nor express any conclusions of law.

g) The Advisory Committee may recommend to the Lead Coroner(s) that a Subcommittee be formed or an external expert/consultant be engaged, if they are of the opinion that additional specialized expertise is required to inform the review and/or the recommendations.

h) It will be the ultimate decision of the Chief Coroner to determine whether a Subcommittee will be established or an expert/consultant will be engaged.

4) Year 3: Year of Report

a) Pursuant to subsections 10.2 (10), (11) and (12) of the *Coroners Act*, the results of the review will be submitted as a report to the Chief Coroner.

b) The report will be drafted by the Lead Coroner(s) with the support of the Secretariat. When drafting the report, the Lead Coroner(s) may use the completed CRTs and any other information deemed relevant, as required.

c) The Lead Coroner(s) will submit a report to the Chief Coroner on or before June 30th of the Year of Report.

d) The final report will be made available to the public in English and French on a Government of Ontario Website.

e) At the discretion of the Chief Coroner, the OCC may release more than one report annually and reports may address individual groupings or multiple groupings of deaths.

f) Reports may include the following sections:

   i. Committee membership;
   ii. Executive summary;
   iii. Synopses of circumstances of the individual deaths being reviewed;
   iv. Group and systemic analyses, which may include statistical analyses;
   v. Recommendations to prevent further deaths, resulting from the review; and
   vi. Any recommendations of a Coroner, and any verdict and recommendations from any inquest related to a construction death occurring in the Year of Review.

g) The report will not include any findings of legal responsibility nor express any conclusions of law.

h) If multiple reports are released in one year, a final report containing a systematic sector-wide analysis may be published.

5. Deferrals

1) Overview

a) The Chief Coroner may defer the review of a death in accordance with subsection 10.2 (3) of the *Coroners Act*:

> **Deferred Review of Deaths**
>
> 10.2 (3) The Chief Coroner may direct that a death shall not be included in the annual review for the calendar year in which the death occurred and shall instead be deferred to review in a later calendar year if:
>
> (a) the death is the subject of an ongoing investigation, prosecution or inquest; or
> (b) the Chief Coroner otherwise determines that it would be inappropriate for the death to be included in the annual review.

b) The Chief Coroner may defer the review of a death on the Chief Coroner's own initiative, without a request made for deferral.

c) The Chief Coroner will also consider requests for deferrals. Requests for deferrals will be required for all deaths that occurred in or after 2024.

d) The latest date of death requiring a deferral request in any given calendar year will be November 30. Deaths occurring in the month of December will be deferred to the year following.

e) For example, a death that occurred in December 2024 would be recorded in 2024 but subject to a deferral request in December 2025.

f) Requests for deferrals will be considered on a case-by-case basis. To ensure transparency and accountability regarding deferral decisions, the Chief Coroner will not consider automatic deferrals or blanket deferrals of multiple deaths (with the exception of deaths occurring after November 30, noted above).

2) Deferrals under subsection 10.2 (3) (a) of the Coroners Act

a) The process for requesting a deferral under subsection 10.2 (3) (a) of the *Coroners Act* is as follows:

i. **Deferral Requests Initiated by the MLITSD**

A. The Secretariat will provide the MLITSD with a Status Document no later than December 1 of each calendar year. The Status Document will include a list containing:

I. All relevant deaths occurring on or before November 30 in that calendar year;
II. Any death(s) occurring between December 1 and December 31 of the previous calendar year; and
III. Any other death(s) deferred from previous calendar years.

B. The MLITSD will complete and return the Status Document to the OCC no later than December 14. This will include any deferral request(s) and any accompanying reasons for each deferral request(s).

C. The Chief Coroner will consider each request for deferral and will return a decision, in writing, no later than December 31, or as soon as practicable thereafter, either approving or denying each deferral request(s).

D. The OCC will share the deferral decision with the family or personal representative(s) of the deceased person and any other relevant investigative/prosecuting agency.

E. If the Chief Coroner approves a request for deferral, the deferral will be for one (1) year.

    I. For example, should the Chief Coroner approve the deferral of a review of a death occurring in 2024, the death would be reviewed in 2026 (rather than 2025, as required under subsection 10.2(1)) and reported on in 2027 (rather than in 2026, as required under subsection 10.2[11]).

F. If, during the deferral period, the MLITSD determines that a deferral is no longer required, the MLITSD must notify the Chief Coroner as soon as practicable so that the death may be included in the next annual review, if feasible.

ii. **Deferral Requests Initiated by other Investigating and/or Prosecuting Agencies**

A. The investigating agency will request the deferral, in writing, to the Chief Coroner no later than December 14 in the calendar year in which the death(s) occurred. The request will include the reasons for deferring the review of the death(s) in question. For clarity, the request may include multiple deaths, but each individual death must be accompanied by its own reasons for deferral.

B. The Chief Coroner will consider each request for deferral and will return a decision, in writing, no later than December 31, or as soon as practicable thereafter, either approving or denying each deferral request(s).

C. The OCC will share the deferral decision with the family or personal representative(s) of the deceased person and any other relevant investigating/prosecuting agency, including the MLITSD.

D. If the Chief Coroner approves a request for deferral, the deferral will be for one (1) year.

   I. For example, should the Chief Coroner approve the deferral of a review of a death occurring in 2024, the death would be reviewed in 2026 (rather than 2025, as required under subsection 10.2 (1)) and reported on in 2027 (rather than in 2026, as required under subsection 10.2 (11)).

E. If, during the deferral period, the investigating agency determines that it requires an extension of the deferral, it must request an extension, in writing, to the Chief Coroner no later than December 14 of the deferral year. The extension request must include the reasons for extending the deferral of the review of the death(s) in question.

F. The Chief Coroner will consider each request for extension and return a written decision approving or denying the extension.

G. If, during the deferral period, the investigating agency determines that a deferral is no longer required, the agency must notify the Chief Coroner as soon as practicable so that the death can be included in the next annual review.

3) Considerations for all Deferrals under subsection 10.2 (3) (a)

a) The Chief Coroner may consider the following factors in deciding whether to approve or deny a request for deferral or extension:

   i. For deferral requests within the first 42 months[1] from the date of the death:

      A. Whether there has been a previous deferral/extension request(s) and, if so, the total duration of the deferral(s)/extension(s);

[1] To accommodate the legislated timelines of an MLITSD investigation (2 years (24 months) per s. 69 of the *Occupational Health and Safety Act*) and prosecution (18 months, per the Supreme Court of Canada's decision in *R. v. Jordan*).

B. Whether there is an ongoing investigation, and, if so, when the investigation commenced (if different from the date of the accident);
C. Whether there is an ongoing prosecution and, if so, when charges were laid;
D. The anticipated timing of any guilty plea, trial or sentencing hearing (if known);
E. Whether an inquest has been called into the death in question, and when the inquest is scheduled;
F. Whether the family of the deceased person has been notified of the CDR process by the relevant investigating/prosecuting agency; and
G. Any other factor(s) that the Chief Coroner deems relevant.

ii. For deferral requests after 42 months from the date of the death:

A. The total duration of any previous deferral/extension requests;
B. The impact of delay on the review process;
C. The impact of delay on any potential recommendations for preventing further deaths;
D. Any feedback from the family or personal representative(s) of the deceased person, including the impact of delay on the family;
E. Whether there is an ongoing prosecution, and the anticipated timing of any guilty plea, trial, or sentencing hearing (if known);
F. Whether there is an ongoing appeal, the nature of any appeal (i.e., conviction/acquittal, sentencing or both) and the anticipated timing of any appeal (if known);
G. Whether an inquest has been called into the death in question;
H. Whether the circumstances of the death involve high public scrutiny and interest;
I. Any other reasons for the deferral or extension request provided by the investigative/prosecuting agency; and
J. Any other factor(s) that the Chief Coroner deems relevant.

4) Deferrals under subsection 10.2 (3) (b) of the Coroners Act

a) The process for granting a deferral under subsection 10.2 (3) (b) of the *Coroners Act* is as follows:

i. If the Chief Coroner otherwise determines that it would be inappropriate for any death(s) to be included in the annual review, the Chief Coroner will outline the reasons behind the deferral, in writing.

ii. The OCC will share the deferral decision with any appropriate party associated with the death, including the family or personal representative(s) of the deceased person and the MLITSD.

6. Confidentiality and Privacy

1) Overview

a) CDR briefs and related materials may contain personal and/ or sensitive information about the deceased person and other persons.

b) CDR participants must respect the requirement to maintain the confidentiality and privacy of the CDR process.

2) CDR Briefs and Related Materials

a) As noted above at subsection 3 (2) (c) (viii), the conduct and provision of services by each Advisory Committee member will be governed by a CDR Member Letter of Agreement. This Agreement will include provisions related to confidentiality, privacy and information sharing.

b) Any other CDR participant must complete an Acknowledge of Duty and Undertaking of Confidentiality in order to access CDR briefs or any related materials. This includes, but is not limited to, Subcommittee members, experts, consultants or any other person engaged to assist with the CDR.

3) Personal Information

a) Requirements for the use and disclosure of personal information are set out at subsections 10.2 (7), (8) and (9) of the *Coroners Act*:

Disclosure of personal information

10.2 (7) A coroner conducting a review under this section shall not disclose personal information to any person who is being consulted or who is providing assistance or expert services for their review if other information will permit the coroner to solicit their input or obtain their assistance or services.

Personal information limited to what is reasonably necessary

(8) A coroner conducting a review under this section shall not disclose more personal information to any person who is being consulted or who is providing assistance or expert services for the coroner's review than is reasonably necessary to solicit their input or obtain their assistance or services.

Use and disclosure

(9) A person who receives personal information from a coroner conducting a review under this section shall not use the information except for the purposes for which they received the information and shall not disclose the information except as required by law.

b) Under subsections 10.2 (15) and (16) of the *Coroners Act*, the wilful use or disclosure of personal information in contravention of subsections 10.2 (7), (8) and (9) is an offence subject to a penalty:

Offence

10.2 (15) No person shall wilfully use or disclose personal information in contravention of subsection (7), (8) or (9).

Penalty

(16) Every person who contravenes subsection (15) is guilty of an offence and is liable on conviction,

(a) in the case of a first offence, to a fine of not more than $25,000; or

(b) in the case of a second or subsequent offence, to a fine of not more than $50,000.

7. Amendments to the Terms of Reference

a) The CDR Terms of Reference may be amended at any time by the Chief Coroner, and with notice to all CDR participants.