



Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury Verdict du jury du coroner

We the
undersigned
Nous soussigné

of City of Ottawa
de _____
of City of Ottawa
de _____
of City of Ottawa
de _____
of City of Ottawa
de _____
of City of Ottawa
de _____

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille: Lesway Given names / Prénom: Keith

aged 52 held at 90 Sparks Street, 6th floor, Ottawa, ON
âgé(e) de qui a été menée à

from the 16th of December to the 18th of December 2009
du a la


By L. McNaughton-Filion Dr. Coroner for Ontario
Par coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

- | | |
|--|--|
| 1. Name of deceased
Nom du (de la) défunt(e) | Keith Lesway |
| 2. Date and time of death
Date et heure du décès | June 24th 2007 |
| 3. Place of Death
Lieu de décès | Saint-Vincent Hospital |
| 4. Cause of death
Cause du décès | Complications of treatment for a traumatic brain injury sustained on June 9th 2005 |
| 5. By what means
Circonstances entourant le décès | Accident |

The verdict was received on the
Ce verdict a été reçu par moi le

18th day of December 20 09

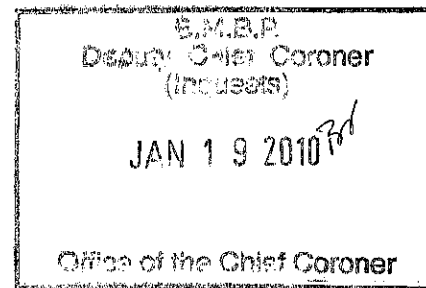

Original signed by Coroner

Keith Lesway Inquest.

JURY RECOMMENDATIONS

Ministry of Labour

1. *Municipalities, contractors, and all other employers in the construction industry must ensure that the adequacy and implementation of the overall health and safety management system is periodically audited to ensure continuous improvement.*
2. *Municipalities, contractors, and all other employers in the construction industry must develop safe operating procedures for every potentially hazardous workplace task.*
3. *Municipalities, contractors, and all other employers in the construction industry must review manufacturer's specifications and operating manuals and instruct all employees in the safe operation of any new equipment (purchased, assembled, and/or fabricated in-house) introduced into the workplace.*
4. *Municipalities, contractors, and all other employers in the construction industry should conduct periodic third party review of procedures for every potentially hazardous work-related task to ensure their adequacy.*
5. *Municipalities, contractors, and all other employers in the construction industry must implement programs that require on-site meetings at the beginning of every workday to discuss workplace safety related issues. This should ensure that employees do not ignore risks as a result of having repeatedly performed a task. The content of these on-site meetings should address specific hazards, conditions, and procedures required to control risks.*
6. *Municipalities, contractors, and all other employers in the construction industry should ensure, when pressure-testing of a water main is carried out, that gauges and workers are positioned in a way that minimizes risk to workers should any parts become dislodged.*
7. *The Government of Ontario should require mandatory training for high-pressure testing of water mains, either in its waterworks distribution course or in some other course, and monitor compliance.*
8. *Municipalities, contractors, and all other employers in the construction industry should ensure that personnel performing hydrostatic pressure testing attend a dedicated training course on the subject and pass a written examination.*



Verdict Explanation

Keith Lesway
December 16 to 18, 2009
The Competition Tribunal, #600, 90 Sparks Street
Ottawa, Ontario

Opening comment:

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

Participants:

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Parties with Standing:

Corporation of the Town of

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Summary of the Circumstances of the Death

This was a mandatory inquest as per Section 10 (5) of the Coroner's Act. Eight witnesses gave testimony and 19 exhibits were submitted, including a series of photographs of the scene and equipment, taken by the Ministry of Labour. Testimony was heard over three days, with deliberation by the jury over the latter part of the second day and continuing on to the third day.

Mr. Keith Lesway was an employee of the Town of Carleton Place. On the morning of June 9, 2005 he conducted a pressure test on a newly installed municipal water main on George Street in the Town of Carleton Place. A new pressure pump was being used, connected to a test pipe that had been constructed months earlier by Mr. Lesway and his co-workers. This test pipe had been used approximately 6 times previously without incident. Within minutes the pipe blew off and hit Mr. Lesway in the head. He was transported to Carleton Place hospital and then transferred for neurosurgical treatment at the Ottawa Hospital. A CT and MRI scan documented diffuse axonal injury, a severe brain injury that left Mr. Lesway in a persistent vegetative state, requiring a tracheotomy to maintain his airway and a permanent feeding tube. He was subsequently transferred to the St. Vincent Hospital for ongoing complex care. He died on June 24, 2007 as a consequence of his traumatic brain injury.

During the inquest, evidence was presented concerning certification in waste water management, the testing of water main pressure, the lack of any commercial equipment available to perform this function, the approach to equipment specifically constructed to meet a need when commercial equipment is unavailable, the approach to new equipment when first used at a job site and the development of a safety culture on a construction site.

JURY RECOMMENDATIONS:

Province of Ontario

Ministry of Labour

1. Municipalities, contractors, and all other employers in the construction industry must ensure that the adequacy and implementation of the overall health and safety management system is periodically audited to ensure continuous improvement.

Coroner's Comments:

Evidence was presented: following Mr. Lesway's injury which lead to his death, the health and safety management system at his place of work was completely revised, including a comprehensive review of practices by an independent health and safety consultant. Another consultant then oversaw the implementation of all policies and procedures. This was not required by any overseeing body.

A "Work Well Audit", designed by the Municipal Health and Safety Association and supported by the WSIB, with 200 elements tested, was then conducted, showing compliance on safety indicators of 88% for his workplace. It was noted that 70% of workplaces who have this evaluation done fail on the first attempt. It was also noted that only workplaces flagged with a history of contraventions had a mandatory audit, thus it is usually not pro-active.

Testimony by witnesses noted the lack of any specific safety indicators being followed or audited on a recurrent, mandatory basis in the construction industry. The jury recommendation seems to reflect their belief that a need exists for a pro-active, regularly audited system.

2. Municipalities, contractors, and all other employers in the construction industry must develop safe operating procedures for every potentially hazardous workplace task.

Coroner's Comments:

Evidence presented indicated that although a safe workplace was mandated, the method to implement this was not structured. A standardized method to identify and approach hazardous workplace tasks does not appear to exist in Ontario.

3. Municipalities, contractors, and all other employers in the construction industry must review manufacturer's specifications and operating manuals and instruct all employees in the safe operation of any new equipment (purchased, assembled, and/or fabricated in-house) introduced into the workplace.

Coroner's Comments:

Since the injury of Mr. Lesway and his subsequent death, his employer has put in place requirements to do the above, both for it and any contractor it hires.

Testimony was given that the pump used the day of Mr. Lesway's death had never been used by employees before, but as it appeared similar to the usual pump, an assumption was made it was no different. The instruction manual was known to be present, attached to the pump but was not used. Later testing by the Ministry of Labour showed the pump functioned as per manufacturer's specifications. The new pump actually had more safety features, but unfortunately arrived set on a higher pressure than the more basic pump. As no employee knew the pressure was adjustable, a higher pressure was placed on the test pipe than had been used before.

The test pipe had been made by Mr. Lesway and fellow workers to measure hydrostatic pressure on the water main; to check for leaks. Testimony was given that this specific test pipe had been used on at least six other occasions with no adverse event. Evidence specified that the main stop component of this pipe was for single use only and that the gripper was missing on the main stop, contributing to its failure.

According to testimony, no commercial tool appears to be available to perform hydrostatic pressure testing on a water main, despite it being a test required whenever a water main is installed. In this case, all components of the test pipe were standard; when constructed no evaluation of safety was made of the final product by a professional, such as an engineer, thus no specific safety instructions could be given. Testimony was given that when water mains are installed in different municipalities, leaks are assessed by a variety of tools, all different and many made in-house.

It was stated that legislation exists requiring any manufactured machine to be operated in accordance with safety standards. The jury appears to feel there is a need for standardized formal structure in the performance, documentation and follow up of this requirement in order to prevent future injury or death in similar circumstances.

4. Municipalities, contractors, and all other employers in the construction industry should conduct periodic third party review of procedures for every potentially hazardous work-related task to ensure their adequacy.

Coroner's Comments:

As noted in the explanation for Recommendation #1, a consultant was engaged by Mr. Lesway's employer to review all health and safety operations subsequent to his injury. Policies and procedures were modified or added and a "Work Well Audit" showed 88% compliance afterwards.

Evidence was given that there is no pro-active evaluation required by any governing body on potentially hazardous work at any required interval. This recommendation appears an attempt to resolve this.

5. Municipalities, contractors, and all other employers in the construction industry must implement programs that require on-site meetings at the beginning of every

workday to discuss workplace safety related issues. This should ensure that employees do not ignore risks as a result of having repeatedly performed a task. The content of these on-site meetings should address specific hazards, conditions, and procedures required to control risks.

Coroner's Comments:

Multiple testimonies indicated that if a task in the workplace had been performed multiple times in the past without incident, it was considered safe, such as the pressure testing performed the day of Mr. Lesway's injury. The jury likely felt that this type of behavior was not unique to Mr. Lesway's workplace.

Evidence showed best practice includes "tailgate meetings", so named as they would be conducted at the work site immediately before the day's work. They would include details of the work required and highlight all safety related issues for the day. It was noted that a standardized tool would be helpful in on-site meetings and that a sign off would be required by an assigned individual in the team in order to confirm its taking place. It was stated that these on-site meetings would likely be variable in length depending on the challenges of the work or the weather, but should be conducted even if the job had been done by the workers multiple times in the past.

6. Municipalities, contractors, and all other employers in the construction industry should ensure, when pressure-testing of a water main is carried out, that gauges and workers are positioned in a way that minimizes risk to workers should any parts become dislodged.

Coroner's Comments:

Evidence from photographs and expert testimony showed the gauge on the test pipe could only be viewed if the person was positioned directly above it, increasing the risk of injury if the pipe failed. As the test pipe was never reviewed by an expert before its operation, this appears to be a recommendation for those who would conduct such a review or evaluate new manufactured equipment.

7. The Government of Ontario should require mandatory training for high-pressure testing of water mains, either in its waterworks distribution course or in some other course, and monitor compliance.

Coroner's Comments:

Evidence showed that Mr. Lesway had been certified and was considered up to date by the province of Ontario in "Water Distribution System" and "Wastewater Collection System – Class 1". Despite this, evidence was given that these courses do not include any training for high pressure testing of water mains and that this type of training is not available in the province of Ontario. As it was stated that this

was considered a hazardous procedure and required each time a water main was installed, the jury appears to feel it is necessary to have a standardized approach instructed and monitored.

8. Municipalities, contractors, and all other employers in the construction industry should ensure that personnel performing hydrostatic pressure testing attend a dedicated training course on the subject and pass a written examination.

Coroner's Comments:

This follows recommendation #7.

Closing comment:

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.



Dr. Louise McNaughton-Filion
Presiding Coroner

18/12/09
December 18, 2009