

# Workers' Compensation Appeal Tribunal

## Decision #175

**Claim No.: 95-1594**

## Reopen Decision #114

Date of Original Notice of Appeal: November 1, 2001

Date of Oral Hearing: August 12, 2010

Date hearing re-opened & closed: October 14, 2010

Date of Decision: November 10, 2010

### **Appeal Committee Members appointed under s. 64 (1) of the *Workers' Compensation Act*, S.Y. 2008, c. 12**

Committee Chair:	H. Leenders
Member representative of employers:	H. Hermanson
Member representative of workers:	M. McCullough

**In attendance:** The Worker's dependent - via telephone  
The Worker's ex-common-law spouse – via telephone  
Observer on behalf of the worker's dependent  
The dependent's representative – Julie Docherty  
Recorder - Vernna Johanson

**Location:** Room #201, 419 Range Road  
Whitehorse, Yukon Territory

## **Introduction**

This appeal was originally before the Workers' Compensation Appeal Tribunal (WCAT) on June 16, 2005 and Decision #114 was rendered on February 10, 2006. That appeal committee found the presumption (to be work-related) had been rebutted and that the worker had made an apparent decision to injure himself. They confirmed the hearing officer's April 15, 2005 decision which concluded that the worker's death did not arise out of and in the course of his employment.

Subsequently the ombudsman investigated an alleged irregularity in the original appeal and recommended the case be reheard. In order to be completely transparent, an entirely new appeal committee was appointed. The case was reopened and heard on August 12, 2010.

[1] The worker's dependent (daughter) and his ex-common-law spouse participated in the hearing via teleconference connection. They testified by affirmation. His daughter was represented by the deputy workers' advocate. An observer attended on behalf of the dependent. The employer was notified of the appeal but did not attend. The proceedings were recorded.

## **Evidence**

[2] The appeal committee considered the advocate's submission, the dependent's and ex-spouse's testimony, board policies as noted below, and the entire claim record No. 95-1594 as well as OH&S files as provided by the board.

## **Documents submitted outside the required timelines**

[3] On March 8, 2010 the deputy advocate was notified that the reopening of the appeal was scheduled for August 12, 2010. On August 9, 2010 a binder of documents was provided to the tribunal. Documentation not previously submitted consisted of diary notes commencing on June 25, 1995 and ending November 3, 1995, which were taken from the deceased worker's personal computer. On August 11, 2010, the day before the hearing, another binder containing documents was submitted. This binder contained Yukon Coroners Service Investigation Notes dated November 6, 1995 to October 25, 2005 not previously submitted or considered by the appeal committee in Decision #114. No request was made to enter any of the documents as evidence during the course of the hearing. These documents were considered by the appeal committee.

Although the documents were provided very close to the hearing and did not meet the required timelines contained in WCAT's Rules of Procedures, the committee was hesitant to postpone the hearing due to the length of time that has passed since the worker's death and the impact this could have on his surviving daughter.

Because this is a re-opening/re-hearing by the tribunal, the documents were not provided to the hearing officer as directed by Policy AP-03, New Evidence at Reviews & Appeals.

## Jurisdiction

[4] Section 65 (6) and (7) of the *Workers' Compensation Act*, S.Y. 2008 (the "Act") provides:

(6) The appeal tribunal may at any time examine, inquire into, reopen, and re-hear any matter that it has dealt with previously and may rescind or vary any decision or order previously made by it.

(7) The appeal tribunal is not bound by its previous rulings or decisions.

Section 65(6)(7) of the *Act* gives the appeal tribunal jurisdiction to hear and decide this appeal.

[5] Originally the worker's ex-common-law partner filed an appeal on behalf of the worker's minor daughter. The daughter, no longer a minor, provided authorization for the workers' advocate office to represent her in the reopening of the appeal. The daughter stated that she disagreed with the hearing officer's April 15, 2005 decision and WCAT Decision #114.

[6] The original claim was filed by the deceased worker's estate administrator on December 19, 1995. Compensation entitlement decisions are made pursuant to legislation in place at the time of injury. In this instance the *Workers' Compensation Act*, S.Y. 1992 as amended to the date of the worker's death, November 5, 1995 should be used to determine the issues of entitlement.

[7] The board provided the following policies to the tribunal as relevant to this appeal under the authority of section 24 (4) of the 2002 *Act*:

- Policy CL-42, Arising Out of and In the Course of Employment
- Policy CL-54, Merits and Justice of the Case
- OHS-02, Accident Investigations

## Evidence from the Record

### Witness Statements given to the RCMP

We will only set out portions of the witness statements with respect to the condition of the truck and the worker's behaviour before discovery of his body.

[8] Co-worker "EH" said she explained to the worker where they were supposed to be dumping. She said she passed him coming and going to the dump site and after that his truck was parked right where they were dumping. After dumping a few more loads and noticing the worker's truck was still parked there she began to wonder where he was. She said:

. . . his truck was parked with lights off, box down. The passenger door was opened but we just kept on working cause we figured maybe he just went out for a walk . . . I went over to the truck and checked it out to see if you know what he, he just went for a walk, to see what he was doing. He wasn't

in the truck so I turned the light on, I looked around and all his stuff was there. His bag, his thermos and his flashlight. There was a letter on the dash that I guess he's been reading so I picked it up and looked at [it] for a second and put it back down and went out and walked around in the catwalk, the passenger door was opened so I just shone my flashlight cause I thought maybe he got hurt or checking the motor to see, lift the hood up or something might have fell on him that's what I figured might have happened.

EH stated she got her truck stuck in front of the worker's truck. She needed to get one of the CAT operators to push her out. While she was waiting for the CAT to come she:

. . . got out and checked around his truck and I looked for him with my flashlight in piles that were already scattered around where we had already dumped.

- [9] Co-worker "DA" told the RCMP that after the lunch break, at approximately 1:15 to 1:30 a.m., he was going to use the worker's truck because his truck was not working properly and the worker's truck was parked in the way of where they were dumping loads. He said:

TA looked around as well before he moved the truck and didn't notice anything. EH [another co-worker] also looked around and couldn't find him. Anyway I got to [the worker's] rock truck and looked around before I got on. I was shining my flashlight to double check on the truck and I found at that point [the worker] behind the cab underneath the rock truck gravel box. It looked like he was facing out but the box was down.

- [10] Co-worker ET stated that he had known the worker for approximately 13 years and had worked with him for the past two seasons. He found him to be a loner. The day before the incident the worker had a conversation with ET where he asked ET if he had ever thought about killing himself. ET responded that he was sure everyone thinks about it. The worker stated that he had often thought about killing himself.

- [11] NH, another co-worker, explained that he operated the same rock truck on the same day the worker had used it. He said the day before the incident he had coffee with the worker and although he was usually quiet, the worker was happy, joking around and outgoing. He stated:

That following day 95/Nov/05 I went to work at 0630 A.M., start work at 0700. I operate a rock truck unit #7301 usually but that afternoon my rock truck broke down, a hydraulic went so I jumped into #7302 rock truck cause it was just idling there. I used it for approx 3 hrs and everything in it was working fine, hydraulics were good, box was working fine, the lever to this gravel box was fine. I parked this gravel truck at 5:30 P.M. at quitting time and it was still in good working condition.

Q. As a driver are you allowed to do minor maintenance to your trucks or is that the mechanics responsibility?

A. It's the mechanics responsibility to do it, it's all his responsibility to fix leaks, etc. We are required to do a minor premature (walk-around) check as a vehicle inspection.

Q. Did you have any problems with the hydraulic system with the gravel box or any other hydraulics in the rock truck unit #7302?

A. None whatsoever.

[12] NS was operating a loader on November 5, 1995. He stated that he did not know the worker very well but on the night of his death when he loaded the worker's truck, "he was reading this mail everytime I was loading his truck he would pull this letter out and then put it in his bib."

[13] TA, heavy duty mechanic and co-worker stated:

At about 11:00 P.M. another operator flagged me down and said that #7302 was parked at the dump site and there was no sign of the operator (the worker). She had climbed into the cab to see if he was in there sleeping. She turned the cab lite on and only saw his lunch pack and a letter on the dash. I went over the truck and shone my flashlight around to see if there was any [sign] of him laying on the ground or around one of the wheels. Seeing that there was no sign of him around the truck, we had to move it out of the dump area, so as the other trucks could continue dumping. I moved the truck about 100 meters and parked it out of the way, then I went back to where it was originally parked and looked for footprints in the snow, thinking maybe he wandered up to the hiway or into the bush to relieve himself. The truck was originally parked with the load dumped and the box down. The passenger door was open, the driver's door was closed.

### **The RCMP Investigation**

[14] A November 23, 1995 letter and accompanying envelope from Cst. Cardinal, Beaver Creek RCMP to the Chief Coroner provides the coroner with a letter and notes found at the scene, as well as a note memo pad and two letters found in the worker's room. Cst. Cardinal writes:

This investigation revealed that it was obvious that it was an apparent suicide. From talking to all witnesses involved and viewing the scene it was evident that there was no foul play involved. The deceased was described by his co-workers as a loner and kept to himself most of the time. One of the witnesses who was a female companion to the deceased was interviewed. Her notes were also included inside the envelope found inside his rock truck where the deceased was found.

- [15] A December 15, 1995 summary report of the RCMP's investigation is provided to the board. Following are excerpts:

On November 06, 1995 Beaver Creek RCMP Detachment received a call at 01:40 A.M. from the [employer's] job site. The call was regarding an employee of the Company found pinned underneath one of the heavy equipment trucks and presumed dead. Location of the incident was . . . .

Police made a patrol to this location. A male person (later identified as [the worker]) was found pinned underneath the box of a rock truck. As a result of the investigation that followed it became quite evident that this accident was the result of an apparent suicide. Notes were found inside the rock truck which showed [the worker's] mind set at the time. The passenger door of the truck was found opened and tracks were noted leading from this door down onto the frame of the truck. There was no indication of foul play or no indications of any type of struggle had taken place at the accident scene.

Follow-up investigation was done and another person who drove the same rock truck on the day shift was interviewed and stated that the truck was working fine. The head mechanic for [the employer] did a mechanical inspection on the rock truck and found it to be in good running condition. A mechanic from Finning also did a mechanical inspection on this truck as well but this report was not released to police upon the advice from [the employer's] legal counsel.

### **The OH&S Investigation**

- [16] The OH&S branch was notified of the fatality. On November 6, 1995 safety officers travelled to the work site, spoke with the RCMP and the Coroner and completed an investigation. The following day, November 7, 1995, they interviewed witnesses.
- [17] A November 7, 1995 (10:00 a.m.) handwritten note reports a phone call by safety officer "LR" The note states:

Out right side of cab, over engine, laid down on frame, waited for box to drop. About 25 seconds for box to drop. Face down on frame. Disjointed note in a notebook. ¾ way thru divorce, mentally bad. Appears to not be an accident. LR did not see letter or notebook. He is to see it or find out how to get copy.

- [18] TA is interviewed by the safety officer. Following are excerpts from his interview:
- Q. What did you observe?

A. First went over to truck, shone light around to see if he was laying on ground around truck. Not uncommon to slip and fall. Climbed into truck and checked on hood, shone light out there. Then drove it out of dump pile about 100 m.

Q. Who discovered body?

A. Another truck broke down. I told him to take #2 truck. [Co-worker] checked fuel gauge and light shone on guy's face. He came and got me.

Q. Did you or [co-worker] touch anything?

A. No. Went and checked out [co-worker's] report. Did not check vitals.

Q. Was there any blood around or underneath truck?

A. No.

Q. Did tracks in snow indicate anyone got off truck?

A. No tracks whatsoever.

Q. Any sign of another truck track close up to the truck?

A. No.

[19] Following are excerpts from DA's statement given to the safety officer:

Q. Why did you take over truck #7302?

A. Frozen half load/leaking oil.

Q. What did you observe?

A. Walk around inspection until came to right side and found [the worker].

Q. Was truck #7302 working properly?

A. Think so.

[20] A November 15, 1995 note to file, signed by two OH&S safety officers states:

#### Description of Incident

[The worker] was working night shift on 5 Nov, 1995. At approximately 0130 Hrs 6 November, 1995 [the worker] was discovered between the vehicle frame and the lowered box of the rock truck he had been operating. Beaver Creek RCMP and the coroner were called to the site. [The worker] was pronounced dead at the scene by the coroner.

On 7 Nov, 1995, we discussed the incident with Cst. Ralph Cardinal RCMP investigator, . . . site superintendent and . . . a first aid attendant who attended the scene. We later obtained statements from other workers who had been at the site during the shift.

No one had been in contact with [the worker] for an hour or two. His truck was running at the dump location, but, there was no sign of him. After searching the area around the truck for some sign to indicate what had happened to

him the truck was moved approximately 100 meters. [The worker] could not be found and the truck was needed. Another driver was told to use the truck. The driver did a walk around the truck and while using a flashlight to check the fuel level he discovered the body.

[The worker] had apparently elevated the box of the his rock truck, opened the right side door, activated the lever to lower the box, climbed down onto the frame, laid down and waited for the box to crush him. The box was raised and half full of frozen dirt. The time from activating the lever until metal to metal contact was tested at 8 seconds. There were no signs of slipping or tripping in the dust and soot between the cab and the frame where [the worker] was found. There were no foot prints noticed on the ground around the truck. [The worker] was found face down over the frame member with his arms crossed under his head. The injury was a crush injury to the upper chest area.

There was no evidence of equipment failure. The truck hydraulic system was inspected by, . . . , the company mechanic, soon after the body was removed. The mechanic states there were no mechanical problems with the truck that could cause the sudden lowering of the box. The hydraulic system has check-valves in the lower part of each cylinder that would prevent the cylinders from retracting in the event of a hydraulic failure.

The evidence indicates that [the worker] deliberately took his own life.

Our conclusion is that this was not an industrial accident or an industrial fatality.

[21] A December 1, 2004 memorandum from the OH&S Manager to Board General Counsel speaks about an information request by the workers' advocate including the OH&S file on the incident. Following are excerpts from the memo:

When RCMP declared it a suicide we quit the investigation. . . . Because the RCMP took the lead and declared it a suicide we did not do much. We have no formal report because of the RCMP decision. . . . There are no mechanical reports. [Safety officer] spoke with Campion and he was refused access. We did not pursue because of circumstance.

### **Behaviour Investigation Reports**

[22] A February 11, 1996 behaviour investigation report to the coroner is completed by James W. Smith, BPE, RCC, RSW (PP), Behaviour Investigator. He states, in part:

The Behaviour Investigator was to examine file information from the coroner's office containing diary notes and letters to the deceased as well as RCMP and pathology findings.

Conclusion: [The worker], struggling to make sense out of ordinary, everyday social encounters, may have been suffering from an undiagnosed mental illness. He appears to have lapsed into a state of paranoia and distrust doubting the sincerity of even closest family members.

In this state of complete dysfunction [the worker] would have been capable of taking his life.

[23] A letter to the worker's ex-common-law spouse by Barb McLean, Dip. Beh. Sc., B.Sc.Psyc, M.Ed. Counselling, personal and family counsellor dated October 2, 1998 states in part:

As per your request, I have reviewed the documents pertaining to the death of [the worker]. These documents together with consultation with you have provided me with a profile of the likely state of [the worker's] mind prior to his death.

Review of the documents, the accident site, and the situation as it appears to have been at the time of death could prompt one to believe [the worker's] death was due to suicide. It seems, however that pertinent information that was not available to the authorities at the time, may suggest that [the worker] was not suicidal. These are as follows: (We will summarize her findings):

1. An AA book was found among his possessions indicating he was attempting to journalize/externalize negative emotions and internalize positive messages.
2. Suicidal ideation is an emotional handicap that results in the subject's loss of energy and interest in maintaining physical health. The worker regularly lifted weights for exercise.
3. When people are suicidal they often feel they are a failure to those they love and because of this they are compelled to write a will or in some way prepare their loved ones for the death. There was no evidence that the worker was attempting to prepare his daughter or any other loved one for his death.
4. On the evening of the worker's death he called his father and was actively making plans for himself and his daughter to go home for Christmas. Such active planning would be considered unusual for someone who was planning suicide.
5. Most suicide victims have a history of attempted suicide. The worker did not have such a history, thus making him a less likely candidate for suicide.

To conclude, there is a lack of sufficient evidence to prove or disprove that [the worker] was truly feeling helplessness to the point of taking his life. It is my opinion that at best, cause of death would most appropriately be deemed “undecided”.

### **The Coroner’s Reports/Investigation**

[24] The Preliminary Death Report by Coroner Doris W. Dryke completed on November 6, 1995 at 01:32 hrs. notes the body was found lying face down between the box and cab of a gravel truck. She reports, in part:

A suicide note was found at the scene as well as the subject’s name.  
At 02:30 hrs. police arrived at the scene where the ambulance was already there with the nurse. The large machine (Rock Truck) was noted parked facing North with the engine running and lights on. The male subject was found underneath the large gravel truck box pinned against the frame on the right side of the machine. . . .

Closer examination to the scene revealed that the subject’s footprints were noted leading to where he was located. He got out of the passenger side of the truck and walked into the location of where he was found.

[25] The Report of Postmortem Examination (Autopsy) dated November 8, 1995 indicates the post mortem toxicology was negative for alcohol, prescription drugs, opiates and cocaine. The cause of death was listed as “crush injury to chest”. Following are excerpts from the Commentary:

The history indicates that this man’s body was found crushed between the box and cab of a gravel truck 30 km south of Beaver Creek. A suicide note was found at the scene.

At post mortem examination this was a healthy man with no evidence of a pre-existing natural disease process to cause or accelerate death or to cause him to collapse.

There were no findings in the internal organs to indicate chronic alcohol or intravenous drug abuse. Toxicological analysis was performed at the Provincial Toxicology Centre on post mortem samples of blood and urine. Screens for alcohol, prescription drug, opiates and cocaine were all negative.

[26] A “Certificate of Coroner” (death certificate) dated February 1, 1996 signed by K. Stewart, Chief Coroner, notes the immediate cause of death as a “crush injury to chest”. The manner of death is “suicide”.

[27] Following are excerpts from Yukon Coroners Service Investigation Notes:

July 30/96 – Spoke with [worker’s ex-common-law spouse]. . . . She obviously disagrees with the determination of “suicide” and is of the opinion that [the worker’s] death is an accident. I indicated that after reviewing all of the investigative information, I felt that the death was a suicide; particularly considering the autopsy/tox.findings, the scene investigation, statements, equipment inspection and psych. consult.

May 20/99 – I talked to James Smith on May 20<sup>th</sup>, 1999 and I forwarded him Barb MacLean’s letter. He felt [the worker] was a person who struggled. He said that while Barb’s comments are true, the opposite can be true also. There are sometimes reasons such as wanting a suicide to look like an accident to account for the fact that there is no suicide note. . . . Direct written diary notes etc. indicate a troubled individual. Also is Barb’s opinion coming from field experience. Barb’s opinion does not hold more weight than Jim’s. Taking into account his mental state and evidence from the scene, etc. the intent has to fit. If ruled undetermined, he would have to have a reason to be under there such as truck not working which is not the case. The mental health sways the case.

June 3/99 – Talked to [the worker’s ex-common-law spouse] and discussed the ruling of suicide. She still does not agree. I told her that her argument is with WCB who are under no obligation to accept our ruling on the cause of death.

[28] A June 2, 1999 letter by Sharon Hanley, Acting Chief Coroner states in part:

The Coroner’s Service is responsible for investigating all sudden, unexpected and unnatural deaths in the Yukon. The manner of death of [the worker] was ruled a suicide.

Based on all the information generated by this investigation, I see no reason to change the previous findings of death by suicide and from my prospective, this case is closed.

### **The Mechanical Inspection**

[29] An inspection of the truck the worker was operating at the time of his death was completed by the employer’s mechanic on November 7, 1995. Following are his findings:

- Control linkage worn but, operating properly
- One loose bolt at joint in linkage. Does not affect operation of hoist valve.
- Hoist valve operating properly. No indication of box sticking.
- Hydraulic lines have minor external chaffing. No indication of failure.
- Rams operating properly, leak down, minimal. (Box will remain elevated on hold position for hours.)

Conclusion: No problems were found with the operation or mechanical condition of 7302 that could cause the sudden lowering of the box. Further, as a mechanic on site where 7302 has been operating for approximately 1.5 years, I am not aware of any complaints regarding 7302’s box suddenly lowering.

[30] An inspection report completed by a Finning mechanic dated November 7, 1995 indicates that the mechanic travelled to the job site and completed a diagnostic test of the hydraulic system. His findings follow:

Visual inspection; no box lift safety pins in holders, box  $\frac{3}{4}$  full up the side boards with frozen dirt. Multiple oil leaks in area of torque, pump drives and pumps, and lines to back side of oil tank. Linkage secure and undamaged. Box pins and hoist cylinders undamaged.

Operational checks: linkage operational and detents evident. No load drop from hold position to raise position. Box hoist operate smoothly. No audio sound of pump cavitation or system relief. System relief set at 2450 PSI (spec. 2450 PSI). Lifting pressure of box approx. 1000 PSI and hold in all positions of lift. Cylinder drift test of 3" in 10 minutes with frozen dirt in box (spec. 5" in 5 minutes with empty box). Operational the checks performed several times to vary temperature ranges.

### **The Deputy Workers' Advocate's Submission**

[31] The advocate submits the worker suffered a work-related accident causing death. She says four things went wrong:

1. The adjudication of the file initially at the board.
2. The Occupational Health & Safety (OH&S) Investigation was seriously flawed.
3. The Coroner made flaws in its investigative analysis.
4. They do not agree with the findings of the RCMP.

[32] The advocate referenced two WCAT decisions from another jurisdiction that dealt with situations and legal issues that, she submits, mirror this claim's issue. The decisions are:

- Decision No. 87/91, Ontario Workplace Safety and Insurance Appeals Tribunal (W.S.I.A.T)
- Decision No. 32/91 (1991), Ontario Workplace Safety and Insurance Appeals Tribunal

[33] She says in this case, the evidence is primarily circumstantial. There is no direct evidence with respect to the events as they occurred because no one was present. It is critical to review each element separately.

[34] The advocate submits the adjudicator relied solely on the decision of the coroner. She says notwithstanding the coroner's ruling, the board is still mandated legally to adjudicate the claim and arrive at their own determination of work-relatedness. That did not happen in this case. The advocate says this claim was adjudicated with 8 documents:

#### Preliminary Death Report

[35] The advocate cites two gross errors in the death report:

1. The statement that a suicide note was found.
2. The comment "closer examination to the scene revealed the footmarks leading to where he was located."

### The Post-mortem report

- [36] The advocate says the post-mortem report repeats the mistake, “a suicide note was found”. The same report says the toxicology report was negative for alcohol, prescription drugs, opiates and cocaine.

### Documents from OH&S Safety Officer

- [37] The advocate says the safety officer spoke to the worker’s ex-common-law wife and told her 8 days post-accident what the investigation showed: they had determined the equipment was not at fault and the death was not work-related.

### December 13, 1995 Adjudicator’s notes to file

- [38] The adjudicator noted that on December 13, 1995 she spoke to the worker’s ex-common-law spouse notifying her that copies of the RCMP investigation and coroner’s report were not available.

On December 20, 1995 the adjudicator indicates the claim does not appear to be acceptable because it would not be considered to be an accident under the board’s legislation (*Workers’ Compensation Act*). The advocate submits by not accepting the claim as work-related, the action was considered deliberate. She submits the adjudicator relied on “what she was told” and a post-mortem examination that says there was a suicide note at the scene. The preliminary death report also mentions a suicide note. She maintains this was seriously flawed because there was no investigative analysis of the facts of the case, the witness statements, coroner’s report, or of an RCMP report.

### December 13, 1995 RCMP letter

- [39] The coroner’s investigation has not happened and this has already been ruled a suicide.

### Notes by Safety Officer

- [40] The advocate speaks to the OH&S officers’ travel, telephone, and workday logs. She says that on Monday, November 7, 1995, less than 24 hours after the incident the OH&S officer wrote in his notes:

Out right side of cab, over engine, laid down on frame, waited for box to drop, about 25 sec. for box to drop. face down on frame. disjointed note in a note book.  
¾ way thru divorce. mentally bad. appears not to be an accident. Did not see I letter or notebook. he is to see it or find out how to get copy.

The advocate says at the time of this note, 24 hours had not passed and this health & safety officer, based on “probable” discussion with people at the worksite decides that it “appears” not to be an accident.

Further notes by the safety officer lists the employees that were working at the time of the incident. After the worker’s name the safety officer writes, “deceased; depressed; divorce problems; 25 seconds to leave cab go to frame; found face down; no signs of slipping or

tripping.” He notes the hydraulic system has check valves that lock the box in position in the event of a hydraulic failure. He further notes that the employer’s mechanic checked the hydraulic system on November 6, 1995 and found nothing wrong.

[41] The advocate speaks about an inspection report dated November 7, 1995. She submits this document is “not any form of mechanical inspection form”. She deduces the mechanic must have written something out and someone else typed it. The conclusion arrived at was that no problems were found with the operation or mechanical condition of truck #7302 that could cause the sudden lowering of the box.

[42] The advocate addresses a November 15, 1995 note to file by the safety officer. She contends “some really gross fundamental inaccuracies and errors were made”. She reads:

[The worker] had apparently elevated the box of his rock truck, opened the right side door, activated the lever to lower the box, climbed down onto the frame, laid down and waited for the box to crush him. The box was raised and half full of frozen dirt.

She says this is a “big mistake. She maintains that if the box of the truck was raised and half full of frozen dirt, it indicates fool-proof that the worker’s death was an accident. If the box was raised and the worker was dead underneath it, something would have happened. She suggests that it is impossible for the box of the truck to be in the raised position. Further, two witness statements state the box of the truck was empty and down.

[43] The advocate submits the safety officer is commenting on someone else’s truck. The co-worker was interviewed at the board. She reads from the witness statement which states the co-worker was questioned why he changed trucks. He responds that he drove a grader until lunch and a haul truck after lunch; he switched trucks because his had a “frozen half load/leaking oil”. She says the safety officer is mistaken and has his facts muddled when he noted that the deceased worker’s truck box was raised and half-full of frozen dirt; the safety officer is talking about this co-worker’s truck.

[44] The advocate continues reading from the safety officer’s report:

The time from activating the lever until metal to metal contact was tested at 8 seconds. There were no signs of slipping or tripping in the dust and soot between the cab and frame where [the worker] was found. There was only one set of foot prints from the cab to the frame. There were no foot prints noticed on the ground around the truck.

She says this is impossible because when the truck was found and prior to the discovery of the body, the first person to approach the truck, not only “circulated” the truck several times with a flashlight in his hand, he walked up and around the truck a couple of times. She says he was getting up and down off the truck. This is the first set of foot prints. Then another co-worker not only got up and down off the truck on three different occasions, but also “circulated” it. A witness statement by this co-worker says she climbed into the cab, then walked around the Catwalk looking for the worker.

The advocate submits the witness statements reveal there were at least three people that they know walked around the truck. There could be more as the truck sat there for 2 ½ hours before the body was found.

[45] The advocate continues to speak to the safety officer's report:

[The worker] was found face down over the frame member with his arms crossed under his head.

She says the photo taken of the worker while still between the box and frame indicates that he is in an upright position and his arms are not over his head, they are by his side. She says the information contained in the safety officer's report is factually incorrect.

[46] The advocate says that although the onsite mechanic checked the hydraulic system and found no mechanical problems, the truck should have been "hooked up to diagnostics" to check out the system in its entirety; this could have also been electrical. She submits the mechanic's report that "has a mere 134 words in it" is a transcription of notes from a mechanic who checked the hydraulics in a truck; it is not conclusive evidence in any way to say nothing was wrong with it.

[47] She submits the safety officer's report 10 days post-accident that relied on one "very short report" and discussion with witnesses conclusively stated the truck was okay and it was a suicide. She contends that anybody who has experience in the investigative process knows that what was done by the OH&S people at that point was not an investigation of any sort.

[48] The advocate speaks about Policy OHS-02, Accident Investigations. She submits that unfortunately the safety officers in this case severely compromised the integrity of this whole issue/case and of the investigative process. Lacking any affirmative evidence, they rendered a report 10 days later that said the worker committed suicide. It was based on the rumour there was a suicide note found on the dashboard, the statements of the worker's co-workers, the preliminary death report that said there was a suicide note, and "probably" the post-mortem investigative report that also said there was suicide note.

[49] She says the safety officers attended the scene because they are compelled to under the OH&S Act and Regulations. They are also compelled under the same legislation to investigate fatalities. She refers to an internal memorandum from the Manager, Inspection & Compliance, OH&S Branch which states, "When RCMP declared it was a suicide we quit the investigation." The advocate says that once it was declared a suicide, "by themselves declaring it was a suicide" and the RCMP agreed, the OH&S department was "hands-off". All the errors in the safety officers' reports and the actions they took not to investigate further compromised the investigation. She maintains the OH&S investigation was flawed.

#### The Coroner's Report/Investigation

[50] The advocate says, in their opinion, the coroner made some serious errors in their investigative process. She submits the adjudicator did not analyze the case, adjudicate the

claim or weigh the evidence; “she merely relied upon the certificate as provided by the coroner on February 1, 1996 or March.” Although the advocate agrees the adjudicator should have waited until receiving the coroner’s report before rendering a decision, from an adjudicative perspective it is not the deciding tool that makes for a decision. The coroner even mentioned this. He said the board has their own decision-making authority.

- [51] She submits the adjudicator received the coroner’s report and did not continue the adjudicative process. The adjudicator received the coroner’s certificate, read “suicide” and based her decision, “in its entirety 100% upon that.” On March 1, 1996, the date the certificate was received, a note to file defines the rationale as “death of worker did not arise out of and in the course of employment.” The advocate says lacking any investigation, any OH&S notes, any RCMP investigative notes, any investigative notes from the coroner’s office, witness statements, etc. the adjudicator made a decision based solely on a ruling from the coroner. She says that is why the adjudicative process was compromised in its entirety.
- [52] From Investigative Notes by Yukon Coroners Service, the advocate submits the coroner based his ruling of suicide on: autopsy/toxicology findings; the scene investigation, witness statements; equipment inspection and psych. consultation. She submits the coroner is not referring to the toxicology of the blood; he is making a finding of suicide particularly because there was a suicide note found at the scene, which they know, there was not. They conclude this is the first error in the analysis of the coroner.
- [53] The second error was an analysis of the scene investigation. She submits the scene investigation was severely compromised because when the truck was found and nobody knew the body was in it, the truck was moved 100 meters. Because of this mistake, there was no scene investigation. It is difficult for them to understand why the coroner is relying on the scene as a determinant of whether this was a suicide or not. The mere finding of the body in the truck is not indicative of suicide.
- [54] The advocate says the witness statements are “just those”. The witness statements are not indicative of suicide. She says the two WCAT decisions [from Ontario] explain why witness testimony is shaky at best. The other problem with the coroner relying on the witness statements is the gathering of the 8 or 9 witness statements over a 10-day period. The witnesses were not sequestered. They were left together to talk about it before statements were given. The witnesses were interviewed by 3 different constables and 2 different safety officers in different locations. There was no consistency to the gathering of witness evidence. She submits this whole investigation was “so severely compromised by this rumour that was started” that the worker committed suicide. The advocate says for the coroner to rely on the witness statements is “very dangerous”.
- [55] The advocate contends the coroner did not have the Finning report on the truck when he made his ruling. She submits that “anyone that relies on 134 transcribed words that the company mechanic put out” is not reliable nor credible to say there was nothing wrong with that truck which caused the box to fall down.

[56] She references the February 11, 1996 report by James William Smith, BPE, RCC, RSW(PP), Behaviour Investigator, and asks the appeal committee to keep in mind that he did not meet the worker. She submits Mr. Smith was looking at “some notes” and he came to his assessment of the situation through that means. He is not a psychiatrist or psychologist. The advocate maintains the board asked Mr. Smith to analyze and assess the deceased’s behaviour because other psychiatrists/behaviour specialists would be hesitant to take a set of notes and come to this conclusion. The advocate says “it is disastrous” yet this is the report that was relied upon by the coroner. She says the coroner calls it a “psych consult” but there is nothing psychiatric about it.

[57] The advocate then references Barb McLean’s, Personal and Family Counsellor, October 2, 1998 report and submits that she captures the worker’s state of mind more accurately. She reads:

To conclude, there is a lack of sufficient evidence to prove or disprove that [the worker] was truly feeling helplessness to the point of taking his life. It is my opinion that at best, cause of death would most appropriately be deemed “undecided”.

The advocate says this is exactly how this should have been handled.

[58] She then turns to the Coroner’s Investigative notes dated May 20, 1999. She reads:

Barb’s opinion does not hold more weight than Jim’s. Taking into account his mental state and evidence from the scene etc. the intent has to fit. If ruled undetermined, he would have to have a reason to be under there such as truck not working which is not the case.

The advocate says this is not the case. The coroner does not know that. The coroner has no idea why the worker was under that truck. She says no one, to this day, 16 years later, has any idea why the worker was under the truck.

She finds it “quite shocking” that the coroner used this rationale to point toward a suicide in this case. She says these are James Smith’s thoughts yet they are used to say that Ms. McLean’s opinion does not have more weight than Mr. Smith’s. Both opinions, she submits, 4 years after the fact should have no determinant in this case.

[59] She maintains there is as much evidence on this file to say the worker did this intentionally as there is to say, because of the position that he was found in, that something was wrong with the truck. The worker could have parked the truck, exited the passenger door because it was faster, and jumped down onto to the frame to have a look and something happened to cause the truck box to come down on him. The advocate says there was no scene investigation. The scene was compromised because the truck was moved.

[60] The advocate submits that the coroner, RCMP and James Smith were all swayed by the notes on file. She contends the worker was keeping notes because he was in an AA program. One

of the fundamental premises of AA is to keep a journal, document it, keep a diary. He was doing this by handwritten notes and by personal computer notes. He was recording what was going on in his life at the time. She says there was chaos, depression, anger and hostility but there was still joy and elation.

- [61] She says the notes, coupled with the witness statements – witnesses who spent a couple of days together before being interviewed and probably “hanging out with each other discussing this thing relentlessly” until they were interviewed by the police – took on a life of its own. It became “unqualified fact” by the people in camp and by the investigative bodies.
- [62] The advocate says the board when investigating and adjudicating a claim are not bound by the coroner’s ruling. It naturally follows that the tribunal is not bound by the coroner’s ruling. She is convinced that if this case ever went to inquest, the ruling of suicide would undoubtedly be changed to undetermined or undecided.
- [63] The advocate says the 1995 *Workers’ Compensation Act* applies in this case. [Although she said 1995 *Act*, she provided excerpts from the 1992 *Act*] – particularly sections 1(1); 5; 36(1)(2); 37(1)(a)(b). She maintains this whole case hinges on the presumption clause.
- [64] The deputy workers’ advocate provided the following to strengthen her argument:
- *Beckon v. Ontario (Deputy Chief Coronor)* (1990)
  - Decision No. 87/91, Ontario Workplace Safety and Insurance Appeals Tribunal (W.S.I.A.T)
  - Decision No. 32/91 (1991), Ontario Workplace Safety and Insurance Appeals Tribunal
- She asks the appeal committee to refer to these cases to assist with their analysis.
- [65] The advocate submits that the standard of proof in this case is the criminal standard of “beyond a reasonable doubt”. The Ontario Court of Appeal case (Beckon) established that the proper standard was the civil standard. The Court provided that where consequences are so significant as in a case such as this – alleged suicide, the probability must be established with clear and cogent evidence. The Court also referred to the common law presumption against suicide. Suicide cannot be presumed to have occurred; on a balance of probabilities the standard is the degree of probability has to be a high one.
- [66] The advocate provided a different scenario of what might have occurred that night, stating someone else could have lowered the truck box on the worker.
- [67] After reading excerpts from the worker’s personal computer diary/notes aloud, she said although the notes indicate much negativity, there are also positive notations. People only concentrated on the negative, none of the positive entries were considered. She says this is not the legal threshold for determining suicide nor is it evenly balanced evidence. She maintains that in compensation law when the evidence is evenly balanced, the benefit of the doubt must always go to the worker.
- [68] The advocate contends there was insufficient evidence in this case to conclude there was a suicide; therefore the presumption is that it is work-related. There is no other reasonable conclusion to arrive at considering the flawed investigations.

[69] The worker's advocate submits the assumption of common law of the presumption against suicide, on top of the presumption of work-relatedness in the *Act*, when analyzed against the foregoing, can only result in a determination of work-relatedness.

#### **Further submission – Finning report**

[70] The committee met on October 14, 2010 and reopened the hearing of Claim No. 95-1594 to discuss and rule on the new interpretation by the deputy workers' advocate on evidence contained in the file. The evidence was in the form of a report by a Finning mechanic in regard to his inspection of the rock truck involved in this case. [The deputy worker's advocate did not realize that report was included in the file. She claims it came as a complete surprise and shock to her and that she would like to look at it and comment on it before the committee made any decision.]

**[Note:** On June 17, 2005, the day after the first appeal hearing into this matter, the previous appeal committee requested that the employer's legal counsel, Campion Macdonald, provide the truck inspection report completed by Finning. On September 13, 2005 the report was provided to the tribunal.

On January 17, 2006, along with a letter closing the hearing, the Finning report was provided to the worker's advocate office. At that time, the advocate's office was given an opportunity to comment on it. The previous appeal committee noted in their decision (Decision #114) that they had received a copy of the service report.]

[71] The inspection was done at the request of the accident employer's lawyers and it and the report were completed on November 7, 1995. A safety officer from the occupational health & safety branch (OH&S) of the board states in an undated note to file:

I spoke with Brian Campion, the lawyer for [the employer]. Mr. Campion said that he ordered the mechanical inspection by Finning of the haul truck involved in the death of the worker. The information is privileged and not available to us. Off the record, Mr. Campion said there was nothing in the report to indicate the equipment was at fault.

On November 27, 1997 Mr. Campion wrote a letter to the chief coroner in regard to the Finning report stating, "No fault or deficiency was found which could explain the incident as being caused by accident."

[72] The committee does not believe the accident employer's legal counsel was trying to deceive the investigators. Rather, the inspection by Finning was done to obtain an independent assessment of the condition of the truck, separate and apart from the one undertaken by the employer's own mechanic.

- [73] The workers' advocate alleged that the Finning mechanic inspected and reported on a different truck, other than the one which was involved in this claim. Her reasoning was based on the fact that the inspection report noted the truck box was half full of frozen dirt. She submitted this matched the description of another truck driven by a co-worker of the deceased.
- [74] We also considered the reason why there would be frozen dirt in the box of the inspected truck. We concluded that since all the trucks were of the same make and were all hauling the same dirt and rock mixture, it is possible that all trucks would have a residue of frozen dirt in their boxes.
- [75] The appeal committee does not have concrete evidence that the truck inspected by the Finning mechanic was the truck involved in the incident. We conclude the report is of little evidentiary value. We will therefore disregard the Finning mechanic's report in our deliberations of this case.

## **Analysis**

This committee is tasked with determining whether the worker's death was self-inflicted or a work-related accident arising in and out of the course of his employment. We realize, in circumstances where suicide is a consideration, the natural presumption is against suicide. Therefore, decision-makers need a high standard of proof as required within the civil standard of the balance of probabilities.

- [76] The committee was presented with a number of cases where workers had been crushed by faulty hydraulic lifts on dump trucks. The deputy workers' advocate also included some cases where the ruling of suicide was overturned as the evidence for suicide was not compelling enough to meet the high standard of proof within the balance of probabilities.
- [77] The advocate claims that since the investigations conducted by the Occupational Health & Safety Branch, the Coroner's Department, and the RCMP were flawed and incomplete, the finding that the worker committed suicide is not based on the evidence. We agree that investigations were not up to the standard we would expect from these parties. However, we also recognize that if the investigations were faulty, it does not necessarily mean the conclusion is also faulty.
- [78] Following are some of the errors in investigation that came to our attention:

1. The Occupational Health & Safety Branch appeared to rely almost entirely on reporting by the coroner and RCMP and did not conduct an in-depth investigation of their own. A December 1, 2004 memorandum from the OH&S Manager to Board General Counsel states:

When RCMP declared it a suicide we quit the investigation. . . . Because the RCMP took the lead and declared it a suicide we did not do much. We have no formal report because of the RCMP decision. . . . There are no mechanical reports. [Safety officer] spoke with Campion and he was refused access. We did not pursue because of circumstance.

Evidently board Policy OHS-02 was not followed.

2. The coroner was presented with a preconceived notion there was a suicide note. This could have resulted in the coroner proceeding with their investigation from that premise. A post-mortem report by L. H. Gray, M.D., F.R.C.P.C., Consultant Forensic Pathologist, indicated she was very thorough in her examination. She reported that no other marks, besides those caused by the crushing, were found on the body.
3. The RCMP also relied on the perception it was a suicide (initially they called the letter found in the worker's truck a suicide note according to the preliminary death report) and proceeded on that basis.

We assume the following because there was nothing on file to indicate otherwise:

- A) Apparently no checking was done to determine if the tracks on the truck platform matched the boots worn by the worker. There was no checking of the tracks where the truck was parked initially.
- B) The truck was not impounded.
- C) The contents of the truck were neither itemized nor listed.
- D) The company mechanic completed an initial inspection on the vehicle.
- E) The co-workers' statements were taken the following day after they had discussed the incident amongst themselves.
- F) No question was asked as to the position of the truck box lever when the truck was found at the scene and then later moved or even when the RCMP attended to the scene.
- G) The accident site was not secured and searched for any additional evidence.

[79] It is imperative therefore that a right interpretation of the evidence is crucial in this case. Both the RCMP and the coroner found the worker's death was due to suicide. We will review the evidence which led them to that conclusion. We will also pursue any evidence that may point to the death being accidental as well as any evidence that may conclude the death was a homicide as the advocate inferred.

## **I Suicide**

[80] First, it is unfortunate the letter found in the cab of the truck was labelled a suicide note. Although it was discounted after closer examination, revealing it to be an old letter from the worker's sister, the committee understands this may have unduly influenced the outcome of the investigations.

[81] The interviews of co-workers at the worksite also led to the suicide conclusion through the following statements:

- And I told him well, I..you know, I think he killed himself. I automatically assumed you know cause. . . it just kicked into me cause his door was opened, you know, I thought okay, he squished himself. E.H.
- He was mostly a loner and kept to himself. T.A.
- He was normally a loner and didn't seem to have too many friends. G.M.

- I wasn't that surprised actually. I know he was up to something because he was acting kind of acting strange for the last week. I had this strange feeling that something was not right. D.A.
- ... (the worker) was a little out of character when I last seen him on Saturday, Nov. 4/95 in camp. N.U.
- Saturday when I seen him he looked terrible,....; I could tell something was really bothering him...; He stood there not saying anything which was unusual. J.P.
- ...he was doing dumb things and looking at this letter constantly. N.S.
- It rattled me to be honest, I know that there was definitely something wrong. I went down the hallway and I said to these guys standing there, I think he is loosing it, you guys should keep an eye on him and something to that effect. E.S.

- [82] Two counsellors gave somewhat conflicting evidence with respect to the possibility of suicide. Barb McLean, Dip. Beh. Sc., B.Sc. Psyc, M.Ed Counselling, in an October 2, 1998 letter to the worker's former common-law wife, pointed out the worker had taken certain steps to improve his life prior to his death. She noted the worker joined AA, was lifting weights for exercise, did not have a will, he was making plans for Christmas, and he had never attempted suicide previously. Her conclusion was that there was a lack of sufficient evidence to prove or disprove the worker was truly feeling helplessness to the point of taking his life.
- [83] In May 1999, a coroner's investigative note relays a conversation with Ms. McLean wherein she was made aware the worker had discussed suicide with a co-worker. When confronted with this evidence she admitted that the opposite of her findings could also be true.
- [84] J. W. Smith's BPE, RCC, RSW(PP) February 11, 1996 report to the chief coroner states the worker appeared to have been suffering from a growing state of emotional despair becoming psychotic towards the last moments of his life. He concluded that the worker, struggling to make sense out of ordinary everyday social encounters, may have been suffering from an undiagnosed mental illness. The worker appeared to have lapsed into a state of paranoia and distrust doubting the sincerity of even closest friends and family. Mr. Smith concluded that in this state of complete dysfunction the worker would have been capable of taking his life.
- [85] Neither of the two counsellors presented any conclusive findings as to the cause of the worker's death although, to some degree, they both agree to the possibility of suicide.
- [86] A diary taken from the worker's personal computer provides evidence with respect to his mental state prior to his death. [We note that an un-notarized copy of that information was provided to the committee, however, we assume it is accurate.] It reveals the worker slipping into a state of paranoia during the last days of his life. He starts to read things into what people say or write and assumes they really mean something else or even the exact opposite. He calls it "playing these word games".
- [87] The deputy worker's advocate reiterated a large number of positive things from the worker's diary thereby claiming the worker could not have been suicidal. It was not the positive things which were contained earlier in his diary but the later entries which, we find, revealed his disorientation from reality.

[88] On October 28, 1995 he writes:

I am getting tired of coming back and having to rewrite, today is my birthday and I am having a great day. I have discovered that lying is what I should have been doing all the time. Don't you know really means; Don't you NO!, which is a Lie and really means You say Yes. This is without doubt the greatest birthday present I have every had. I now understand the talk. I now understand the words, and I am going to lie ever.....

At the end he added this: **"I WILL NEVER LIE AGAIN!! I DON'T LIE"**

[89] One of the last entries in his diary also indicates insight into the worker's relationships. He thinks that the person he wanted to have a relationship with is a hooker and even worse that his own mother might be one as well. He calls these "devastating realizations". Were they enough to produce a state of depression and paranoia to the point he felt helpless to cope with his lot in life?

[90] Notes written by the worker also indicate a deterioration in his mental state and his inability to accept reality. They are filled with opposites such as "mean" and "nice", i.e. "I hate your guts" to "I love you"; "I will never speak to you again" to "I hope you and I never part".

[91] One of his last notes contains the following: "Is there anyone I can call – I'm afraid not, I will...Is there anything I can do – I'm afraid not, I will..."

[92] The loader operator mentioned that the worker kept pulling out a letter and reading it every time he was waiting to be loaded. A letter from the worker's sister, dated July 23, 1995, was found in the truck and assumed to be the letter the worker was reading constantly. This was initially thought to be the suicide letter. Certain notes were found on the letter which indicated the worker was re-reading it with his new-found word game theory. At the top of the letter is handwritten, "ARE YOU ALIVE". Was the worker leaving a message for anyone who knew the language?

[93] E.H. mentions that after lunch on her first trip back to the dumping area, she "seen everybody running over like, medic or first aid person run over to this truck with her bag well, I automatically assumed you know cause .. it just kind of kicked into me cause his door was opened, you know, I thought okay, he squished himself." It appears that all of a sudden it hit her that with only the passenger door open and no sign of the driver around the truck there was only one other place the worker could be. Her first thought was that it was self-inflicted.

[94] In order for the worker to have committed suicide he would have to do the following:

- 1) raise the dump-box of the truck ( since he had just dumped a load of dirt, the box was probably still up)
- 2) activate the dump-box lever located on the left side of the driver's seat

- 3) get up, walk across to the other side of the truck
- 4) open the door in order to exit onto the platform located on that side
- 5) clamber down to the frame of the truck, and lay down under the descending dump-box.

(It is possible that he may have opened the passenger door before and then reached over and activated the dump-box lever from that side of the truck)

[95] The above procedure would have to be executed within a certain number of seconds. As a long-time operator of this particular rock truck, the worker would know the time it would take for the box to lower.

[96] The deputy worker's advocate submits that more than one person accessed the platform that night looking for the worker. From documentation contained on file, it appears this is true. E.H. mentioned she walked around in the catwalk; however, only one set of tracks was found from the cab to the frame. The preliminary death report states:

Closer examination to the scene revealed that the subject's footprints were noted leading to where he was located. He got out of the passenger's side of the truck and walked into the location of where he was found.

Further, in a letter dated December 13, 1995 Constable Cardinal of the RCMP writes:

The passenger door of the truck was found opened and tracks were noted leading from this door down on to the frame of the truck. There was no indication of foul play or no indication of any type of struggle had taken place at the accident scene.

[97] The company mechanic, after inspecting the truck, reported on November 7, 1995 that he was "looking for a possible cause of sudden box lowering by itself". His conclusion was that no problems were found with the operation and mechanical condition of truck #7302 which could cause the sudden lowering of the box.

## **II Accidental**

[98] In order for the worker's death to be accidental and thus meet the criteria of "arising in and out of the course of employment", there has to be evidence the worker was underneath the dump box for a reason. We propose some probable scenarios:

- 1) A mechanical malfunction of the hydraulics that lowered the box.
- 2) Some noise from that area of the truck that the worker investigated.
- 3) Went out to check the oil (he apparently let it get low some time before and was reprimanded for it) and then when on the platform, slipped and fell onto the frame.

[99] The first one of the scenarios would indicate the worker was cognizant of some sort of trouble and consciously went to investigate it. As an experienced driver it is not likely he would place himself in that position knowing that a mechanic was on duty that night and it was not in his job

description to check into mechanical breakdowns. But more importantly the worker did not take his flashlight with him so he could see what was happening. E.H. mentions in her statement to the police, "He wasn't in the truck, so I turned the light on, I looked around and all his stuff was there. His bag, his thermos and his flashlight."

It was dark out and a flashlight would be required to see any details in the area of the hydraulics. No doubt, he would also need some sort of tool; however, there is no mention of a flashlight or any tools found near the scene.

- [100] Another statement by E.H., the co-worker who also was operating a rock truck that night, is worthy of note. She says ". . . his truck was parked with lights off, box down." With the truck lights off it would make it more difficult to see anything clearly.
- [101] The second scenario suggests a definite requirement for a flashlight in order to check out what the problem could be.
- [102] The third scenario is perhaps the most plausible of the accident possibilities as the worker had expressed almost a week earlier he could get fired because his truck had run out of oil. We assume the oil refers to hydraulic oil as he mentioned "an oil line off of the compressor". If this is what happened, the worker would be checking for oil sprayed on the truck deck or checking the compressor line: both activities would require his flashlight.
- [103] Also, there is no mention of the box-lift lever being found in the up position, indicating that the box was raised and then could have accidentally lowered by itself. It is not the ordinary that stands out to those involved in this case, certainly had the lever been up someone would have noticed it and mentioned it.

### **III. Homicide**

- [104] Although the advocate mentioned the possibility of foul play, the lack of any evidence or motive appears to rule that out. The coroner's thorough examination of the body indicated no bruising on any other part of the worker's body which would either indicate a fall or where force had been applied to place the worker in the area where he was found. The committee members hesitate to even mention this as the very thought of homicide would cast a cloud of suspicion on a number of people.

### **CONCLUSION**

- [105] We realize the onus of proof that is required of this committee and that any decision reached must be based on evidence that goes beyond the balance of probabilities. We also point out the bulk of evidence is circumstantial and as such is open to interpretation to some degree. Reasonableness is also a major factor in arriving at a decision.
- [106] We have already expressed our concern with some of the investigations that were undertaken as well as the speed of the conclusion arrived at by investigators. We also reiterate the fact, stated earlier in our preamble to our analysis, that although the investigations may not have been up to our expectations, the conclusion reached may not necessarily be wrong.

[107] Based on the evidence available to us we conclude, on the balance of probabilities, that the worker committed suicide. We base our findings on the following:

- 1) The worker's mental state prior to the incident as born out by his notes and diary, as well as the testimony of some of his co-workers.
- 2) The opinion of counsellors who were presented with the worker's notes and diary and who concluded the possibility of suicide in this case.
- 3) The fact that a mechanical inspection did not indicate anything wrong with the truck to cause a sudden lowering of the truck box.
- 4) The footprints going from the cab to the frame of the truck.
- 5) The absence of any other reasonable explanation as to the worker's presence under the box of the truck.
- 6) The worker's flashlight seen in the cab of the truck.
- 7) The post-mortem report by the forensic pathologist.

## **DECISION**

The appeal is denied. The hearing officer's April 15, 2005 decision is confirmed.

Dated this **10<sup>th</sup> day** of November **2010** in the City of Whitehorse, Yukon Territory.

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M. McCullough, Member

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H. Leenders, Committee Chair

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H. Hermanson, Member

### **Committee Members:**

H. Leenders	Committee Chair
H. Hermanson	Member
M. McCullough	Member