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CORONER'S CASE: Chenoa FRASER

Date of Death: 30 June 1986

Place of Death: Snowdrift, N.W.T.

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Chief Coroner's Report into the Death of

Chenoa FRASER

Date of Death - 30 June, 1986

Place - Snowdrift, N.W.T.

Report of Chief Coroner Donna Thomas.

This Coroner's case was initially handled by Coroner Lloyd Anderson. Upon conclusion of his investigation he decided against a formal inquest and held a meeting with the R.C.M.P. members and the Chief and Sub Chief of the Snowdrift Band. Out of this meeting came valid recommendations which should be given consideration for implementation. Along with the recommendations from the formal inquest held on the 9 February, 1987.

As Chief Coroner, I have made recommendations as well, some of which are similar to those of the jury and committee. The jury's verdict and recommendations, the committee's report and a copy of a list of suggestions from the Acting Head of Occupational Health and Safety are attached.

BRIEF HISTORY

The water truck which is owned, maintained, licensed and insured by the G.N.W.T. was driven by Stan Desjarlais, an employee of the Snowdrift Band. Desjarlais was on his way to pick up two fellow workers, the first being Jonas Catholique, when Chenoa Fraser ran in front of the truck. She was struck by the front of the truck, knocked down and then run over by the rear wheels.

Contrary to what many people thought and by what is implied by

continued ...

some of the recommendations of the jury and the committee, Desjarlais was NOT making a water delivery at the time of the accident. He was alone in the vehicle as he was picking up fellow workers to complete the water deliveries for that day.

TESTIMONY

From the evidence given at the inquest, we learned that Desjarlais was driving at a safe speed. There was nothing to indicate that alcohol or drugs were involved. Stan Desjarlais had received no special training or instructions in the driving or operation of the water truck. What knowledge he had was derived by observing the former driver for a couple of months. He is the holder of a Private Class License.

Witnesses stated that there had been a dog on the roadway. The dog was tied up to a tent frame. Two of the witnesses made mention that at the time they thought the dog might be run over because it did not move out of the way.

Stan Desjarlais was aware of the dog and when questioned stated that he turned into the area between Jonas Catholique's house and Archie Catholique's warehouse because the dog was on the road. Otherwise, he would have stopped on the main road as was his usual practice.

FINDINGS

After hearing all the evidence, studying the photographs and visiting the area where the accident took place, I concur with the jury and the committee that it was a very unfortunate accident

By implementing the recommendations of the jury and the committee,

continued ...

possibly we can prevent another such accident from happening in the future.

Chief Coroner's Recommendations

Some of the following recommendations are the same as those of the jury and committee:

- Workers should not be picked up or dropped off at any place other than the garage. This holds for lunch time as well as the beginning of the work day. This would reduce the number of times the vehicles are on the road.

- Vehicles should be equipped with back-up beepers and other audio equipment which should be used when approaching play areas, blind corners and residences.

- Drivers of service vehicles should have some instruction and training before driving on their own. There should be some basic test that they have to pass before they are eligible to drive a water, sewage, oil or gravel truck.

- A back-up driver should also be trained.

- Temporary buildings (the tent frame) should not be situated in such close proximity to the road.

- A study done to see what safety devices can be implemented on the present service vehicles to provide drivers with a better view.

- In future, if possible, all delivery vehicles should be cab over engines.

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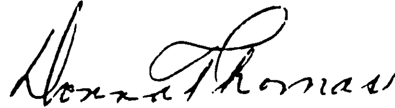
- Dogs should not be tied up close to roadways used by delivery vehicles.



Donna Thomas,
Chief Coroner in and for the
Northwest Territories

DT/ebi
May 19, 1987

JURY FINDINGS

Date: February 9, 1987

INTO THE DEATH OF Chenoa **FRASER**

The **JURY** has considered the evidence and this is their findings:

WHO died? Chenoa FRASER

WHEN did the deceased die?

a) **Date:** June 30, 1986

b) **TIME:** 1:13 p.m.

WHERE did the deceased die?

Snowdrift

HOW did the deceased die?

The water truck ran over her.

BY WHAT MEANS did the deceased die?

Accident

RECOMMENDATIONS BY THE JURY:

1) All truck and snow machine owners should be more careful when driving in town.

2) All trucks should be returned to the D.P.W. garage at noon hour. From now on there will be no more picking up of employees.

3) Water truck - there will be three people working, at all times. Speed limit will be fifteen miles per hour.

This is the third accident which has happened in Snowdrift that children have been run over by trucks. We hope this is the last.

Signed: Mod Casaway
George Marlowe
Auguste Enzoe
Alfred Lockhart, Foreman
Charlie Catholique

CORONORS REPORT

SUBJECT: ACCIDENTAL DEATH OF CHENOA FRASER OF 86 - 06 - 30

On Saturday Sept. 13, 1986 a meeting was held at the R.C.M.P. OFFICE, in SNOWDRIFT for the purpose of establishing some guidlines that may prevent further accidents of this nature.

In attendance were;

CORPORAL D. KORTASH _ R.C.M.P.
CONSTABLE A. OTTERMAN - R.C.M.P.
FELIX LOCKHART - SNOWDRIFT BAND CHIEF
ANTIONE MICHELE - SNOWDRIFT BAND SUB CHIEF
LLOYD E. ANDERSON - CORONOR

The meeting was brought to order at 14:20 hours.
A brief review of the circumstances surrounding the accident was discussed by all present.
R.C.M.P. accident report and all witness statements unanimously concurred with the finding that the driver in this situation had no chance in preventing this accident and therefore no charges were laid.

It was also unanimously agreed that our input could best be served by recommendations at the local level, rather than by holding a formal Coronors Inquest.
CORPOROL D. KORTASH stated that a 30 mph (50 km) vehicle speed limit is in effect in all areas within the Settlement boundries, unless Local by - laws state otherwise.
It was agreed that this speed limit was too high in many congested areas within the Snowdrift Village. It was resolved that CHIEF FELIX LOCKHART would hold a meeting with all Local vehicle drivers and impress on all concerned the importance to minimize vehicle speeds within the village boundries.

With input from everyone present it was resolved that the following recommendations be made:

1. THAT A SECOND PERSON BE PRESENT IN THE VEHICLE CAB WHILE UNDERWAY, TO ACT AS A SAFETY LOOK - OUT.

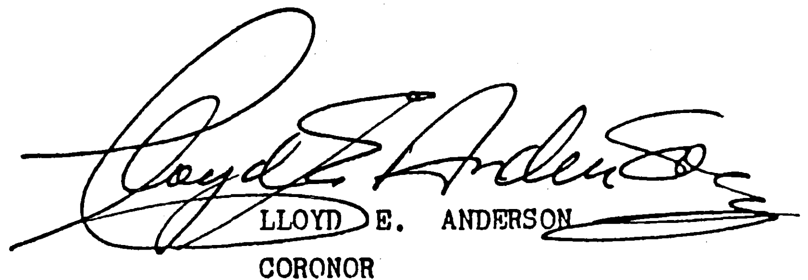
2. THAT AT LEAST ONE PERSON BE PRESENT OUTSIDE OF VEHICLE DURING BACKING - UP MANEUVERS, WITHIN CONFINED AREAS TO ACT AS A SAFETY LOOK - OUT.

3. THAT AN AUDIO WARNING SYSTEM DEVICE BE INSTALLED ON VEHICLE TO BE ACTIVATED DURING ALL BACKING UP MANEUVERS.

4. THAT THE RECOMMENDATIONS MADE FROM 1 to 3 INCLUSIVE BE MADE APPLICABLE TO THE FOLLOWING VEHICLES CURRENTLY BEING USED IN SNOWDRIFT:

WATER DELIVERY TRUCK
OIL DELIVERY TRUCK
SEWAGE PUMP OUT TRUCK
GRAVEL DUMP TRUCKS

5. THAT CHILDRENS PLAY THINGS ie SWINGS ETC., BE REMOVED FROM CONFINED AREAS THAT MAY PRESENT A POTENTIAL HAZARD, FROM THE VEHICLE, WHILE MANEUVERING.



LLOYD E. ANDERSON
CORONOR

c.c.

CORONORS OFFICE - YELLOWKNIFE N.W.T.
SNOWDRIFT R.C.M.P.
SNOWDRIFT BAND COUNCIL

RECEIVED
FEB 19 1987
CHIEF CORONER

February 12, 1987

DONNA THOMAS
CHIEF CORONER
DEPT. OF JUSTICE
CH-3

Inquest Into The Death of Chenoa Fraser at Snowdrift on February 9, 1987

The following list of suggestions may assist you in making recommendations that may in the future prevent a similar accident:

1. I commend the jury for its bold recommendations to eliminate the use of service vehicles used for picking up employees for work. It is one that I would have put forward to curtail the number of times service vehicles are driven around and between housing units.

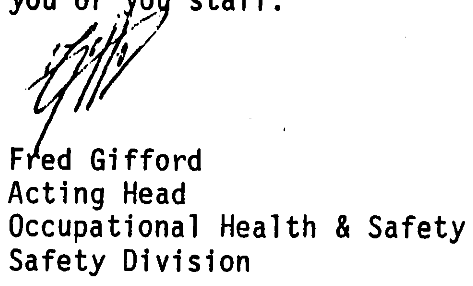
2. The possible purchase of cab over engine service vehicles, as this type of cab would provide the driver with the optimum forward vision.

3. Installation of a mirror at the front of the vehicle by the left hand fender which would provide the driver a view of the front of the vehicle that is out of his field of vision. This type of mirror is used on some school buses.

4. Restrict all service vehicles & mobile equipment to community designated roadways except when making service calls.

5. Annual mechanical vehicle inspections to be carried out by a qualified (licenced) mechanic. Possible insurance coverage may be invalid if mechanical repairs are made by non qualified personnel.

The Occupational Health and Safety Section is committed to public safety and is willing to provide assistance and expertise to you or you staff.



Fred Gifford
Acting Head
Occupational Health & Safety
Safety Division

Re: <u>Chenoa FRASER</u>

LEGEND RE PHOTOGRAPHS:

(1) Jonas Catholique's house
(2) Tent frame
(3) Archie Catholique's warehouse
(4) Truck pulled into this area
(5) Dog on road

A child's swing attached to the warehouse (3) can best be seen in the last photograph.

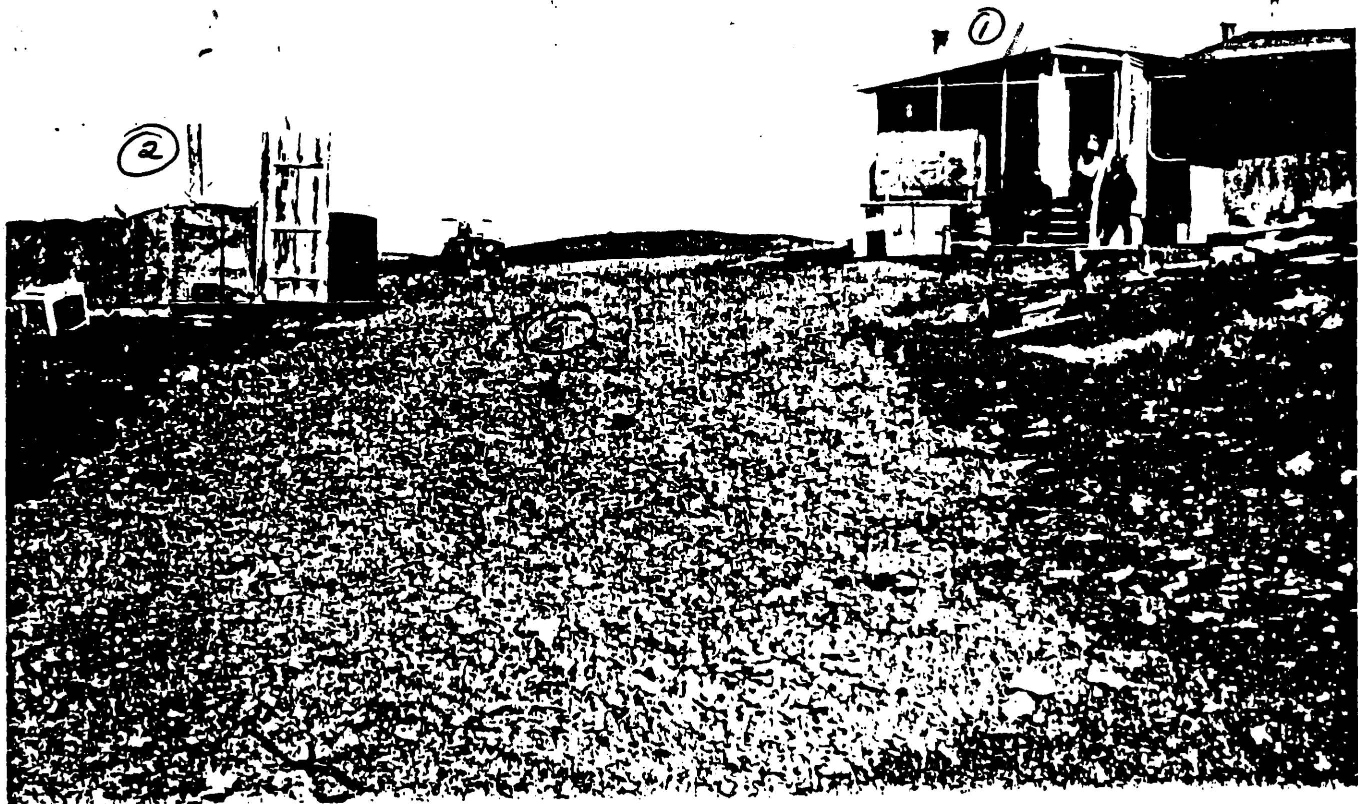
The truck would just have turned in by the warehouse when the little girl ran in front of it.

The photographs are misleading as to space between buildings. In reality, the area is much more confined than what the photographs portray.

Actual photographs of the xeroxed ones along with many others are available for viewing at the office of the Chief Coroner.

Donna Thomas
Chief Coroner in and for the
Northwest Territories

DT/ei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