Learning from tragic workplace fatalities

The first annual report of the Construction Death Review Committee makes seven recommendations to prevent falls from heights.

Working at heights is a major construction hazard. Between 2009 and 2024, 43 per cent of all construction deaths were fall-related. These tragedies have left lasting impacts on the families, workplaces, and communities of those who died on the job—and show the importance of workplace safety. The first annual report from the Construction Death Review (CDR) Committee looks at why fall-related deaths are still happening and how to prevent them.

The CDR Committee, led by Ontario's Chief Coroner, Dr. Dirk Huyer, released its first annual report in July 2025. The report discusses data from 131 fall-related deaths that occurred between 2009 and 2024 and the findings of the first review. The review focuses specifically on 26 fall-related deaths that happened between 2017 and 2023.

Key factors influencing the risk of a deadly fall

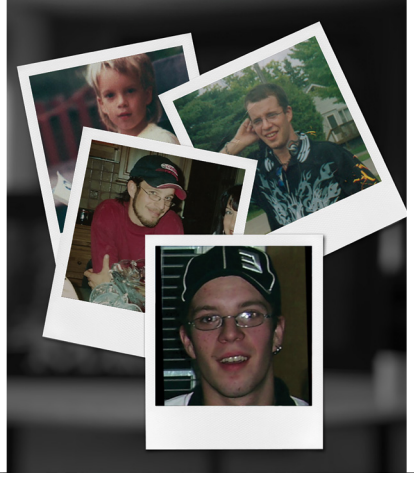
The report explores some trends in the data for the 131 fatalities[1]:

- **Age:** Workers over 55 were overrepresented among those who died. While older workers represent less than 20 per cent of the construction population, they made up 35 per cent of the 131 deaths.
- **Work experience:** Many of those who died were new to their job or the industry. Twenty-six of the 131 workers were in their first year on the job, and four workers were completing their first day.
- **Compliance:** Almost 77 per cent of the workers in the group of 26 deaths who were exposed to a hazard over three metres in height had received working at heights training. However, 63 per cent of of them were not using fall protection or were using it incorrectly at the time of their death.
- **Day of the week:** Approximately 54 per cent of the 131 deaths occurred between Thursday and Sunday—with nearly 25 per cent occurring on Fridays.

Seven recommendations for a safer future

With the goal of preventing future falls, the report includes seven recommendations for the Ontario government and its industry partners:

1. **Compliance:** The Ministry of Labour, Immigration, Training, and Skills Development (MLITSD) and the Chief Prevention Officer (CPO) should improve compliance with working at heights training and fall protection regulations.
2. **Supervision:** The Provincial Labour Management Health and Safety Committee – Construction (PLMHSC) should explore how to improve supervision on construction projects where there are fewer than five workers—and those workers are working at heights. This committee is part of IHSA's Labour-Management Network and directly advises the Minister of Labour, Immigration, Training, and Skills Development following Section 21 of the *Occupational Health and Safety Act* (OHSA).
3. **Competency:** The MLITSD should consider changing the *Regulation for Occupational Health and Safety Awareness and Training* (O. Reg. 297/13) to require that supervisors complete Working at Heights training if they might supervise a worker who uses fall protection. This training should contribute to the requirements of competent supervision under the OHSA.
4. **Homeowner and small business education:** Several government bodies should work together to teach new small business owners and homeowners about their health and safety obligations. This recommendation is directed to the Government of Ontario; the MLITSD; the Ministry of Municipal Affairs and Housing; the Ministry of Public and Business Service Delivery and Procurement; the Ministry of Finance; the Ministry of Economic Development, Job Creation and Trade; and the Workplace Safety and Insurance Board.



5. **Industry collaboration:** The same group of government bodies should work with industry partners, such as IHSA, home insurance companies, building permit providers, and retail stores, to share information with small business owners and homeowners.

6. **Case studies:** The CPO should encourage all Working at Heights training providers to use real-life stories of workers who have fallen from a height. The videos about Michael Fisher and Dean Maguire that IHSA produced with Threads of Life as part of the *See Something, Say Something* initiative in the *Keep Your Promise* campaign are an example.

7. **Funding:** The Government of Ontario should approve resources and funding that support these recommendations.

Timelier recommendations for prevention

The Government of Ontario changed the *Coroners Act* (R.S.O. 1990, c. C.37) in March 2024 to replace mandatory inquests for deaths in construction workplaces with annual reviews of groups of deaths. The new process provides timelier recommendations for improving work conditions.

Each year, the *Coroners Act* requires the CDR Committee to review all worker deaths from the previous year (though the Chief Coroner may decide to review a death in a later year in some situations). As part of the review, the CDR Committee looks at the circumstances of each death, finds common issues, and makes recommendations to prevent future incidents. These findings are published in a report the following year.

The CDR Committee is made up of an Advisory Committee and a Secretariat. The Advisory Committee includes government, industry, labour, and safety representatives with expert knowledge of the construction industry, while the CDR Secretariat is chaired by coroners and supported by members of the Office of the Chief Coroner's Inquest Unit.

Dr. Huyer shared details about the next report at a meeting of the PLMHSC in July 2025: the CDR Committee will release it in June 2026, and it will include a review of 47 construction deaths with a variety of causes. Dr. Roger Skinner is the Lead Coroner for this report.

Family perspectives on workplace tragedies

Workplace tragedies deeply affect the families of those who died on the job. The review process encouraged families to participate by providing information about their loved ones or the circumstances of their deaths. The family testimonials, which are included in the report, describe who these workers were outside of the workplace: they were parents, partners, friends, colleagues, sports fans, and more. These perspectives personalize their deaths by showing that every worker who dies on the job is a valuable member of a workplace, a family, and a larger community.

Threads of Life, a Canadian charity that supports those affected by workplace injury, illness, or death, is also involved in the review process as an Associate Member of the Advisory Committee.[2] Through this role, they provide expertise on issues that relate to families.

[1] *The report looks at several trends, including sex, age, experience, location of fall, use of fall protection equipment, size of company, sub-sector, unionization, season, day of the week, and time of day. However, the report says it's worth further exploring the trends related to age, work experience, use of fall protection equipment, and day of the week.*

Read the full report on our website.

[2] *Shirley Hickman was the Executive Director of Threads of Life until she retired in 2025. Eugene Gutierrez became the Executive Director after her retirement. Both are listed as Associate Members in this report.*

Learn more about Threads of Life.