11.0 INJURY/ INCIDENT REPORTING AND INVESTIGATION PROGRAM

PURPOSE

1. The purpose of this procedure is to facilitate timely and accurate reporting and investigation of the incident details to the WSIB, the Joint Health and Safety Committee and/or Health and Safety Representative, senior management and the Ministry of Labour (when required).

2. The purpose of this procedure is to further determine the root cause of an incident so that corrective action may be taken to immediately prevent future incidents.

SCOPE

The following categories of injuries and illnesses will be reported, regardless of the nature or severity of the event:

- fatality
- critical injury
- lost time injury
- health care
- first aid
- property damage
- near miss
- fire
- environmental release
- occupational illness

DEFINITIONS

Critical Injury

A critical injury is an occupational injury of a serious nature that:

1. Places life in jeopardy,
2. Produces unconsciousness,
3. Results in substantial loss of blood,
4. Involves a fracture of a leg or arm, but not finger or toe,
5. Involves the amputation of a leg, arm, hand or foot but not finger or toe,
6. Consists of burns to a major portion of the body, or
7. Causes loss of sight in an eye.

Major Injury

A major injury is an occupational injury or illness that results in an absence from work or school beyond the date of the occurrence and/or requires medical attention.

Minor Injury

A minor injury is an incident that impacts a worker or student only the day of the occurrence and requires first aid only.

Near Miss/Property Damage
A near miss incident or damage to property is an unsafe or hazardous condition that did not result in serious consequences to worker or student health and safety. A light fixture falling next to a worker or damage to a School Board vehicle, without harming any worker, student or members of the public in anyway are examples of near misses and property damage. These types of incidents shall be investigated by the manager, supervisor, or principal to determine if the equipment or structures have become hazardous as a result of the incident. Investigating these types of incidents may also prevent a similar occurrence in the future that could possibly end in a more severe result.

11.1 PROCEDURES

A. IMMEDIATE RESPONSE

1. All staff are responsible for reporting each and every incident, regardless of severity, to their supervisor/principal immediately. Workers shall complete the NPSCDSB **Employee Accident Report Form 1**, and a **WSIB Form 6** as soon as possible after a work-related injury, incident or illness.

2. If first aid is required, the supervisor/principal ensures that appropriate first aid is provided.

3. The supervisor/principal shall ensure that the staff member or student is provided transportation to the nearest medical care facility, if required.

4. If there is a possibility that any circumstances surrounding the incident may be imminently dangerous to anyone, the supervisor/principal shall take immediate steps to prevent further injury.

5. The supervisor/principal shall begin the investigation, as soon as practical once the injured staff member or student is attended to and there is no further threat of harm. The Supervisor/Principal or Health and Safety Officer will compile the data needed to complete the NPSCDSB **Injury/Illness/Incident Investigation Report Form 2.**

B. ACCIDENT/INCIDENT INVESTIGATION

1. The Supervisor/Principal or Health and Safety Officer with authority over the workplace shall conduct the investigation for each incident occurring in the workplace and complete the appropriate forms.
   a. Interview process:
      The supervisor/principal or Health and Safety Officer will interview all eye witnesses and people involved immediately following the incident in a safe and confidential location. All interviews will be documented. Following the interviews, the Injury/Illness/Incident Report Form 2 will be completed as indicated.

2. The Supervisor/Principal or Health and Safety Officer with authority over the workplace is responsible for:
   a. Securing and inspecting the scene of the incident and all tools and equipment being used at the time of the occurrence; obtaining and reviewing all pertinent work procedures and safety measures; training and equipment maintenance records; and interviewing and documenting, as accurately and completely as possible, the chronology of events and actions taken by those involved in the occurrence. The investigation should include, where appropriate, use of photographs, sketches and drawings of the injury/incident site indicating sizes, distances and weights of objects involved.

   b. Assessing all available information and determining the causes of the incident and all contributing factors;

   c. Recommending and implementing immediate corrective action which will prevent or reduce the risk of recurrence of a similar incident and recommending additional corrective actions, as required for approval and implementation at a future date.

Analyzing the Incident
All incidents shall be analyzed to determine cause. There are three levels of cause:
1. Immediate
2. Underlying
3. Root

Some questions to consider during an investigation:
1. Was the worker distracted? If yes, why?
2. Was a safe work procedure being followed? If not, why not?
3. Were safety devices in order? If not, why not?

C. REPORTING PROCEDURES

1. The supervisor/principal and/or Health & Safety Officer shall complete the NPSCDSB **Injury/Illness/Incident Investigation Report Form 2.** Forms must be copied and sent immediately to the HR Department and the Health and Safety Officer for processing. The WSIB Claims Administrator will then complete the **WSIB Form 7** immediately and completely.

2. The Employer's report form must include the following information:
   a. Detailed background information and documentation which may include photographs and/or sketches;
   b. Concise description of corrective actions taken;
   c. Completion date for implementation of additional corrective action.

3. Where the worker seeks medical attention, the **WSIB Functional Abilities Form** must be completed by the treating medical practitioner and returned to the WSIB Claims Administrator.

4. Work-related incidents involving lost time will be recorded and reported in accordance with the appropriate absence reporting procedure.

5. The Senior Management team shall receive copies of all employer reports of incident, worker reports, and all relevant documentation.

D. CRITICAL INJURY

When a critical injury occurs, the employer shall notify the Ministry of Labour immediately by telephone and contact a worker member of the JHSC.

1. Where a person is killed or critically injured in the workplace, no person shall interfere with, disturb, destroy, alter, or carry away any wreckage, article, or thing at the scene, or connected with the occurrence until permission has been given by a Ministry of Labour inspector, except for the purpose of:
   a. Saving a life or relieving human suffering,
   b. Maintaining an essential public utility service or public transportation system, or
   c. Preventing unnecessary damage to equipment or other property.

2. The employer will attend to, and obtain medical attention for the worker.

3. The employer shall establish an investigation team consisting of the supervisor of the critically or fatally injured worker and a certified worker member of the JHSC.

4. The WSIB Claims Administrator must fill out a **WSIB Form 7** and submit it for processing to WSIB.

5. The investigation team will:
   a. Investigate the accident at the site (without disturbing the evidence),
   b. Interview witnesses and if required, co-workers and supervisory personnel, and
   c. Prepare a written report (NPSCDSB **Injury/Illness/Incident Investigation Report Form 2**) of their findings and recommendations to prevent a recurrence.

6. The completed report will be copied and:
   a. Faxed to the Ministry of Labour, within 48 hours,
   b. Distributed to members of the JHSC or Health and Safety representative,
   c. Forwarded to the applicable Union Local, if any,

d. Forwarded to the Health and Safety Officer for the Board, and
e. Forwarded to the Manager of Plant Services.

E. COMMUNICATION OF PROGRAM

This program is communicated to all managers, supervisors and employees through:

- Principals' meetings
- bi-weekly Admin Council meetings
- postings on bulletin boards
- orientation of new employees
- coaching of employees found to have contravened this procedure.

F. TRAINING

All members of the Joint Health and Safety Committee, Worker Health and Safety Representatives, Supervisors and Managers will receive training as indicated in the Training Matrix.

11.2 PROCEDURE FOR PRINCIPAL (OR DESIGNATE) IN CASE OF' A CRITICAL INJURY TO A WORKER

Provide first aid treatment

↓

Call 911

↓

Call Health & Safety Officer
472-1560 (ext. 2227)

↓

The H&S Officer will immediately call Ministry of Labour Inspector
8:30 a.m. - 5:00 p.m. – 1-800-461-6325
(Dial this number and you will hear an automated voice message.
Press 0 to talk to someone from the Ministry of Labour.)
After 5:00 p.m. – 1-800-268-6060
(This number will connect you to the Ministry of the Environment. They will accept the message and page a field worker from the Ministry of Labour)
(Do not interfere with scene of accident)

↓

In consultation with Health & Safety Officer, prepare a written report of occurrence within 48 hours to be faxed to the MOL at 1-705-564-7076

The written report required by the Act shall include:

a) The name and address of the contractor and the employer;
b) The nature and the circumstances of the occurrence and the bodily injury sustained;
c) A description of any machinery or equipment involved;
d) The time and place of the occurrence;
e) The name and address of the person who was killed or critically injured;
f) The names and addresses of all witnesses to the occurrence;
g) The name and address of the physician or surgeon, if any, by whom the person was or is being attended for the injury.

Nipissing-Parry Sound Catholic District School Board

11.3 EMPLOYEE ACCIDENT REPORT FORM 1

This form must be completed as soon after the incident as possible.

Upon completion, please fax immediately to 705-472-4220.

Env.: ____Land ____Water ____Air ____Other

Safety: ____First Aid ____Healthcare ____Lost Time ____Near Miss ____Property Damage
____Critical Injury ____Fire ____Occupational Illness ____Other

PERSONAL INJURY (Actual/Potential)

Employee Name: _____ Job Title: _____

Department: _____ Date/Time of Incident: _____

Type of Incident (i.e., slip/trip/fall): _____

Nature of Injury/Body Part (i.e., broken hand, cut above the eye): _____

Regular job: ☐ Yes ☐ No Time on the job: ☐ >2 years ☐ >1 year ____months ____weeks

PROPERTY DAMAGE/ENVIRONMENT (Actual/Potential)

Area: _____ Equip #/Location: _____

Department: _____

Date/Time of Incident: _____

Type of Incident (i.e., explosion, fire, spill, emission, etc.): _____

Estimated Value of Property Damage / Extent of Contamination/Amount of Spill: _____

_____

Witnesses: _____

Describe in detail what happened (provide specific names/details of equipment, tools, materials, parts, etc.):

_____

_____

_____

_____

Date and time reported to supervisor/principal: _____

Routing (completed form must be submitted to WSIB Claim Administrator and Principal)

Sent to	Date Sent	Note Action Taken (then forward to next person on list)
Principal/Supervisor		
WSIB Claims Administrator		
Health & Safety Officer		
Manager of Plant & Health & Safety		

Signature of Employee: _____ **Date:** _____

11.4 WSIB Form 6

WSIB ONTARIO CSPAAT

Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373

6 Worker's Report of Injury/Disease (Form 6)

Please PRINT in black ink

Claim Number

A. Worker Information

Last Name	First Name	Social Insurance Number
Address (number, street, apt., suite, unit)		Telephone
City/Town	Province / Postal Code	Alternate/Cell Phone
Job Title/Occupation (at the time you were hurt)	Date you started with employer dd mm yy	How long have you been doing this job for this employer?
Only check if you are one of the following: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer		Date of Birth dd mm yy
Sex ☐ M ☐ F / Your Preferred Language ☐ English ☐ French ☐ Other		Would an interpreter be helpful? ☐ yes ☐ no
Are you a member of a union? ☐ yes ☐ no	Do you authorize your union to represent you in this claim? ☐ yes ☐ no	If **yes**, do you consent to the disclosure of verbal claim file status information to your union representative? ☐ yes ☐ no
Provide your Union Name and Local		

B. Employer Information

Company/Employer Name		
Address		
City/Town	Province	Postal Code
Your Immediate Supervisor's Name		Company Telephone

C. Accident/Illness Dates & Details

1. Date and hour of accident/Awareness of illness dd mm yy ☐ AM ☐ PM
   Date and hour reported to employer dd mm yy ☐ AM ☐ PM

2. Who did you report this accident/illness to? (Name & Position) Telephone

3. Area of injury (Body Part) - **(Please check all that apply)**

☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s)	☐ Teeth ☐ Neck ☐ Chest	☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis	Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm	Right ☐	Left ☐ Wrist ☐ Hand ☐ Finger(s)	Right ☐	Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg	Right ☐	Left ☐ Ankle ☐ Foot ☐ Toe(s)	Right ☐

☐ Other:

Are you: ☐ Left Handed ☐ Right handed

4. Did the accident/illness happen on the employer's property or work site? ☐ yes ☐ no
   Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):

5. Did it happen outside the Province of Ontario? ☐ yes ☐ no
   If **yes**, indicate where (city, province/state, country):

6. Have you hurt this area(s) of your body before? ☐ yes ☐ no

7. Do you have any prior related WSIB/WCB claims? ☐ no ☐ yes - in Ontario ☐ yes - Outside Ontario

A guide to complete this form is available at www.wsib.on.ca

WSIB ONTARIO CSPAAT

6 Worker's Report of Injury/Disease (Form 6)

Please PRINT in black ink

Claim Number

Worker Name - Last Name	First Name	Social Insurance Number

C. Accident/Illness Dates & Details (continued)

8. If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.
or
If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

9. When did you first start to have problems with this injury/condition?

10. If you did not report this to your employer right away, please tell us the reason why.

11. If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names & positions.

	Name	Position
1.		
2.		

12. The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).
Did you receive a copy of the Form 7? ☐ yes ☐ no

The Workplace Safety and Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer.

D. Health Care Information

Give your Health Professional your WSIB Claim number.

1. Did you get first aid or care at work ☐ yes ☐ no If **yes**, when dd mm yy and by whom (Name):

2. Where did you go for health care, for your injury, outside of work? **(Check all that apply)**

	Facility/Hospital (Name & Address)	Date of Visit (dd/mm/yy)		Date of Visit (dd/mm/yy)
☐ Nursing Station ☐ Emergency Department ☐ Admitted to Hospital			☐ Ambulance ☐ Health Professional Office ☐ Clinic	

3. Were you prescribed any medications/drugs? ☐ yes ☐ no

4. Were you referred for any other treatment or tests? ☐ yes ☐ no

5. Did you talk to your health professional about going back to regular or modified work? ☐ yes ☐ no If **yes**, were you given any work limitations? ☐ yes ☐ no

6. Did you tell your employer you went for medical treatment? ☐ yes ☐ no **If no, please tell your employer right away.**

If **yes**, when? dd mm yy and to whom? Name Position

WSIB ONTARIO CSPAAT

6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number

E. Lost Time & Return to Work

1. After the day of accident/illness:

- ☐ I returned to work to my **regular job** and **did not** lose any time or pay.
- ☐ I returned to **modified duties** and **did not** lose any time or pay.
- ☐ I **lost time and/or pay** (e.g. regular pay, shift differential, bonuses, premiums, etc.).

→ Date you first lost time and/or pay: dd mm yy

2. If you lost time, have you returned to work? ☐ yes ☐ no

If **yes** ▶ Date of your return to work: dd mm yy ☐ regular work ☐ modified work

If **no** ▶ Did you discuss return to work with your employer? ☐ yes ☐ no

Does your employer have modified work? ☐ yes ☐ no

F. Earnings (Do not include overtime here)

1. Rate of pay: $ per ☐ hour ☐ week ☐ other:

2. Usual number of pay hours: per ☐ week ☐ other:

3. If you lost time from work after the day of accident/illness, did your employer continue to pay you? ☐ yes ☐ no

4. Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.). ☐ yes ☐ no

5. At the time of the accident/illness did you work for more than one employer? ☐ yes ☐ no

G. Declarations and Signature

By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return to Work".

It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board.
I declare that all of the information provided on pages 1, 2, and 3 is true.

Signature	Date (dd/mm/yy)

If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

Signature	Relationship:	Date (dd/mm/yy)	Telephone

Personal information about you will be collected throughout your claim under the authority of the Freedom of Information and Protection of Privacy Act and will be used to administer the Workplace Safety and Insurance Act, 1997, your claim and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, and others as authorized by the Workplace Safety and Insurance Act and the Freedom of Information and Protection of Privacy Act. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.

A more detailed PRIVACY STATEMENT for workers may be found at www.wsib.on.ca or by calling toll free at 1-800-387-5540.

WSIB ONTARIO CSPAAT

6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number

K. Additional Information

0006A (06/07)

The Workplace Safety & Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer

11.5 INJURY/ILLNESS/INCIDENT REPORT FORM 2

This form must be completed as soon after the incident as possible
by the Principal/Supervisor/Health and Safety Officer/WSIB Claims Administrator.
Upon completion, fax immediately to WSIB Claims Administrator (705-472-4220)
and Health and Safety Officer (705-472-0507)

Nipissing-Parry Sound Catholic District School Board

Env.: ____Land ____Water ____Air ____Other

Safety: ____First Aid ____Healthcare ____Lost Time ____Near Miss ____Property Damage
____Critical Injury ____Fire ____Occupational Illness ____Other

Date of Investigation: _____

PERSONAL INJURY (Actual/Potential)

Employee Name: _____ Job Title: _____

Department: _____ Date/Time of Incident: _____

Type of Incident (i.e., slip/trip/fall): _____

Nature of Injury/Body Part (i.e., broken hand, cut above the eye): _____

Regular job: ☐ Yes ☐ No Time on the job: ☐ >2 years ☐ >1 year ____months ____weeks

PROPERTY DAMAGE/ENVIRONMENT (Actual/Potential)

Area: _____ Equip #/Location: _____

Department: _____

Date/Time of Incident: _____

Type of Incident (i.e., explosion, fire, spill, emission, etc.): _____

Estimated Value of Property Damage / Extent of Contamination/Amount of Spill: _____
_____

Witnesses: _____

Witness Statement (required where applicable): _____

_____

Describe in detail what happened (provide specific names/details of equipment, tools, materials, parts, etc.):
_____

_____

_____

_____

Were digital or other photos taken of the scene? ☐ Yes ☐ No _____
(If yes, please attach)

Contributing Behaviours	Contributing Conditions	Other Contributing Factors
___Operation without authority	___Inadequate guarding	**Personal Factors**
___ Failure to warn	___Improper PPE/Dress	___Inadequate physical capability
___ Failure to secure/make safe (lockout)	___Defective Tools/Equip/Materials	___Lack of knowledge
___ Operating at improper speed	___Safety Devices Inoperative	___Lack of skill
___ Making safety devices inoperable	___Hazardous Arrangement	___Stress, physical or mental
___ Removing safety devices	___Congestion	___Improper motivation
___ Use of defective equipment/tools	___Inadequate Warning	___ _____
___ Using equipment improperly	___Housekeeping	___ _____
___ Failure to use PPE	___Hazard. Env. (gas/dust/fumes)	___*No Personal Factors*
___ Improper loading	___Noise Exposure	**Job Factors**
___ Improper body placement	___Temperature Extremes	___Inadequate supervision
___ Improper handling techniques	___Improper Illumination	___Inadequate leadership
___ Working on moving/dangerous equip	___Inadequate ventilation	___Inadequate purchasing
___Distracting/Teasing/Horseplay	___Radiation Exposure	___Inadequate maintenance
___Failure to lockout	___Insufficient data	___Inadequate work standards
___Using hands instead of tools	___ _____	___Wear and tear
___Failure to follow rules/instructions	___ _____	___Abuse or misuse
___Acting aware of insufficient data	___ _____	___ _____
___ _____	___ _____	___ _____
___*No contributing behaviours*	___*No contributing condition*	___*No job factors*

Provide details relating to Behaviours, Conditions and Other Contributing Factors: _____

_____

_____

_____

_____

_____

_____

Describe corrective and/or preventative actions (what, why, how): _____

_____

_____

Identification of person(s) responsible for corrective/preventative action(s): _____

_____

_____

Are you aware of any prior related problem to the area of injury: _____

_____

_____

CORRECTIVE/PREVENTIVE ACTIONS
Identify Outside/Emergency Services called in: _____

Describe any recommendations to prevent recurrence: _____

_____

_____

PARTICIPANTS AT INVESTIGATION (Principal/Supervisor or Health and Safety Officer carries out the investigation, but may include those on list)

	Print Name and Sign	Date
Employee:		
Supervisor:		
JH&S Committee Member:		
H&S Officer:		
Plant Dept.:		
Other:		

Once the investigation has been completed and the report has been completed, retain a copy and fax immediately to the H&S Officer and WSIB Claims Administrator.
Any photographs or other media documentation should be forwarded with this report.

Principal/Supervisor Signature: _____ **Date:** _____

Routing (Completed form must be submitted to H&S Officer, H&S Site Rep Worker, WSIB Claims Administrator, JHSC and Senior Administration)