OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

PROCEDURE PR.593.HR

TITLE: HEALTH AND SAFETY - ACCIDENT REPORTING AND INVESTIGATION
Date issued: August 1999
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1.0 OBJECTIVE

1.1 To provide direction for reporting and investigating employee workplace accidents.

1.2 To provide direction for reporting, and investigating critical injuries and fatalities in the workplace that may occur to staff, students or visitors.

2.0 DEFINITIONS

2.1 An accident is any workplace related event that causes harm to a person.

2.2 The Occupational Health and Safety Act**,** by regulation, defines a critical injury as an injury that is serious in nature that:

a) places life in jeopardy;

b) produces unconsciousness;

c) results in a substantial loss of blood;

d) involves the fracture of a leg or arm, but not a finger or toe;

e) involves the amputation of a leg, arm, hand or foot, but not a finger or toe;

f) consists of burns to a major portion of the body; or

g) causes the loss of sight in an eye.

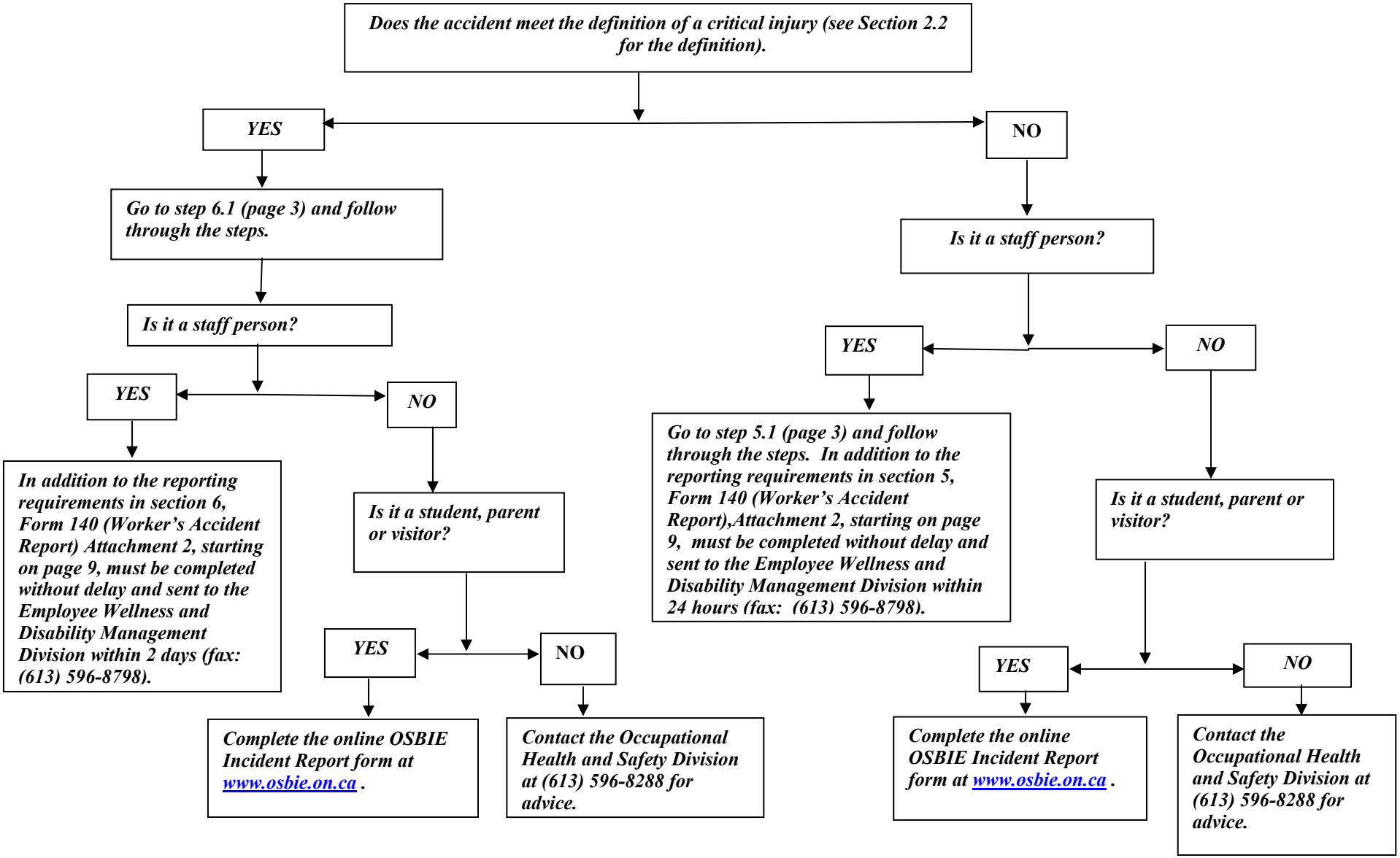
2.3 For the purposes of this procedure, the Act refers to the *Occupational Health and Safety Act.*

2.4 The acronym WSIB means the Workplace Safety and Insurance Board.

3.0 RESPONSIBILITY

Superintendents, principals, managers, supervisors and the Supervisor Occupational Health and Safety are primarily responsible for the implementation of this procedure.

4.0 ACCIDENT / INCIDENT ACTION FLOW CHART



5.0 PROCEDURE - EMPLOYEE ACCIDENT (NO CRITICAL INJURY)

5.1 When an employee is injured at a workplace and the injury is not a critical injury (as defined):

a) First-aid treatment will be applied without delay;

b) Transportation will be arranged for the injured person so that professional health care can be delivered, if required;

c) The principal/manager/supervisor or designate will be notified as soon as is practical. Notification may be by telephone, or other direct means. Electronic mail (e-mail) is not acceptable.

5.2 Accident Investigation

5.2.1 An accident investigation will be undertaken without delay by:

a) The principal, manager, supervisor or designate; and

b) The Occupational Health and Safety Division (optional).

The investigation will include a search or examination of the physical evidence and inquiry as to how and why the accident occurred. An "Accident Investigation Form" (Attachment 1) is to be completed and a copy faxed to the Occupational Health and Safety Division at (613) 596-8284 within 48 hours of the occurrence.

6.0 PROCEDURE - CRITICAL INJURY TO ANY PERSON – CAUSED BY A WORKPLACE ACCIDENT

6.1 When a person is critically injured (as defined) at a workplace:

a) First-aid treatment will be applied without delay;

b) Transportation will be arranged for the injured person so that professional health care can be delivered;

c) The principal/manager/supervisor or designate will be immediately notified. Notification may be by telephone, or other direct means. Electronic mail (e-mail) is not acceptable.

6.2 When there is a fatality at a workplace, the principal, manager, supervisor or designate will be notified immediately, in person. Electronic mail (e-mail) is not acceptable.

6.3 Duties of the Principal/Manager/Supervisor/Designate

a) The principal, manager, supervisor, or designate will, in turn, immediately notify the Occupational Health and Safety Division. Notification may be by telephone or by other direct means (electronic mail (e-mail) is not acceptable).

b) The principal/manager/supervisor/designate will ensure that the scene is secured until the Ministry of Labour or the Supervisor Occupational Health and Safety, on behalf of the Ministry of Labour releases it.

6.4 Duties of the Supervisor Occupational Health and Safety

As per the *Act*, the Supervisor Occupational Health and Safety will immediately notify (by telephone or other direct means) the following parties:

a) the Ministry of Labour;

b) The management co-chair of the ~~a~~ Joint Occupational Health and Safety Committee;

c) The worker co-chair of the ~~a~~ Joint Occupational Health and Safety Committee;

d) The workplace health and safety representative at the site.

6.5 Accident Investigation

6.5.1 An accident investigation will be undertaken immediately by:

a) The principal, manager, supervisor or designate;

b) Certified members of the Joint Occupational Health and Safety Committee, or the school/department health and safety representative or one or more members designated by the Committee; and,

c) The Supervisor Occupational Health and Safety.

The investigation will include a search or examination of the physical evidence and inquiry as to how and why the accident occurred. An "Accident Investigation Form" (Attachment 1) is to be completed and a copy faxed to the Supervisor Occupational Health and Safety at (613) 596-8284 within 48 hours.

6.5.2 It is important to note that it is a contravention of the *Act* to disturb the accident scene without permission of a Ministry of Labour inspector. Therefore, until a Ministry of Labour inspector arrives at the scene, the role of the investigator(s) should be restricted to securing the accident site and preliminary questioning of the witnesses.

Note: It is NOT a contravention of the Act to disturb the scene for the purposes of:

a) Saving life or relieving human suffering;

b) Maintaining an essential public utility service or a public transportation system; or,

c) Preventing unnecessary damage to equipment or other property.

6.5.3 Within 48 hours of the occurrence, the Supervisor Occupational Health and Safety will send a written report of the circumstances of the occurrence to the Ministry of Labour.

6.5.4 A copy of the written report referred to in 6.5.3 above will also be provided to the Joint Occupational Health and Safety Committee.

7.0 APPENDICES

Attachment 1: Accident Investigation Form
Attachment 2: Form 140 – Worker's Accident Report

8.0 REFERENCE DOCUMENTS

Critical Injury – Defined, R.R.O. 1990, Regulation 834
Occupational Health and Safety Act and Regulations for Industrial Establishments
Board Policy P.053.HR: Health and Safety

Accident Investigation Form

Part A: Critical injury and Employee Accident Information

Name:_____ Position: _____

School/site:_____ Location of Accident: _____

Date of Incident: _____ Time: _____ Time reported to Principal/Supervisor: _____

Was the injury (yes/no): a critical injury? _____ a fatality? _____

If a critical injury, state the nature of the injury: _____

Part B: Background Information

What specific process/task was the person/employee doing at the time? _____

Was any specific equipment involved? _____

Who assigned the work? _____

Did the person/employee receive instructions before starting work? YES_____ NO_____
If, yes:

General instructions_____

Specific instructions _____

How much experience did the person/employee have at the work involved? _____

Were established rules, regulations and procedures being followed? _____

Was personal protective equipment (PPE) being worn? _____

Witness(es): _____

Part C: Accident Description

Explain exactly what happened (what, where, when, who and how). A separate sheet may be attached if more space is required. A sketch/diagram may be included.

_____

_____

_____

_____

_____

_____

Part D: Accident Analysis

Identify the immediate cause (s):

_____Operating equipment without authority
_____Failure to warn
_____Failure to secure/make safe
_____Operating at improper speed
_____Making safety devices inoperable
_____Removing safety devices
_____Using defective/improper equipment
_____Using equipment improperly
_____Failure to use personal protective equipment (PPE) properly
_____Improper loading
_____Improper lifting
_____Servicing equipment in operation
_____Horseplay
_____Influence of alcohol/drugs suspected
_____Inadequate or excessive illumination
_____Inadequate guards or barriers
_____Inadequate ground support
_____Inadequate/improper protective equipment
_____Defective tools, equipment or material
_____Congestion or restricted action
_____Inadequate warning system
_____Fire and explosion hazards
_____Substandard housekeeping
_____Hazardous environmental conditions: gases, dusts, smoke, fumes, vapours
_____Noise exposure
_____Radiation exposure
_____High or low temperature exposure
_____Inadequate ventilation
_____Ground (rock) conditions
_____Other:_____

Identify the underlying cause(s):

_____Inadequate physical/mental capability
_____Lack of knowledge
_____Lack of skill
_____Physical or mental stress
_____Improper motivation
_____Inadequate work standards
_____Abuse or misuse
_____Inadequate supervision
_____Inadequate engineering
_____Inadequate purchasing
_____Inadequate maintenance
_____Inadequate tools/equipment
_____Wear and tear
_____Other:_____

Corrective action(s) recommended to prevent a recurrence of the accident:

Action	Responsibility	Date to be Completed	Date Completed

Part E: Signatures Required

Investigation completed on (date) _____ by:

Name	**Signature**
Principal/Manager/Supervisor/Designate	
Joint Occupational Health & Safety Committee member	
Joint Occupational Health & Safety Committee member	
Supervisor Occupational Health and Safety	

FAX TO

Supervisor Occupational Health and Safety at (613) 596-8284

FOR OFFICE USE ONLY

Received on (date) _____ by _____

WORKER'S ACCIDENT REPORT – Form 140

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

Workplace Safety & Insurance Board Requirements:

Employers are required to maintain a record of all work related accidents, and submit accident information to the WSIB within 3 days of the injury. Employers must ensure that first aid/advice is given immediately, or if necessary provide immediate transportation to a Health Care facility.

Injured Workers are required to complete an accident report immediately and authorize their Health Care Professional to provide information on their functional abilities. **PLEASE REFER TO THE BACK FOR INSTRUCTIONS.**

All **Critical Injuries** (those producing unconsciousness, substantial loss of blood, fracture of legs or arms, amputation, major burns or serious eye injuries) **MUST BE REPORTED IMMEDIATELY** by telephone to Employee Wellness and Disability Management, tel. # (613) 596-8250.

WORKER INFORMATION

Surname: _____ Given Name(s): _____

Home Address (street, city, postal code): _____

Home Phone: (_____)_____Sex: _____M _____F Date of Birth: _____

Work Location(School): _____ Social Insurance No.: _____

Occupation: _____ Employee Number (EIN): _____

Immediate Supervisor: _____ Phone: _____

ACCIDENT INFORMATION (TO BE COMPLETED BY THE WORKER)

DATE and HOUR of ACCIDENT?

Date _____Hour _____ a.m./p.m.

Will you be seeing medical attention? YES_____NO_____

If **YES**, have treating health professional complete Functional Abilities Report (Page 2 of Accident Report).

Name & Address of Health Professional:

_____

DATE and HOUR accident reported?

Date _____Hour _____a.m./p.m.

Accident reported to?

_____

NOTE: All lost time for workplace injuries/disease must be authorized by health official.

If there is lost time from work due to your accident, please state:

DATE and HOUR YOU LAST WORKED?

Date _____Hour _____a.m./p.m.

Area of body injured: _____(indicate right or left side if applicable)

This injury is: _____a new injury **OR** _____a recurrence injury (Claim number/date of injury) _____

WHERE DID THE INJURY OCCUR? (location and room number) _____

Name of Witnesses:_____

What happened to cause the injury? (Please give specific details)

Give a description of any machinery/equipment involved: (size, height, weight, etc.)

_____

WORKER'S SIGNATURE: By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 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 (WSIB), with information about my functional abilities for a timely return to work. I declare that all the information provided on this report is true. (It is an offense to deliberately make a false statement to the WSIB).

Signature: _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY THE SUPERVISOR

NORMAL WORKING HOURS:

from _____ to _____

HOURS WORKED ON DAY OF INJURY:

from _____ to _____

NORMAL WORKING DAYS:

___ _____Monday thru Friday
_____Other(specify)_____

(SUPERVISOR) MADE AWARE OF THE ACCIDENT/INJURY ON:

Date _____ Hour _____ a.m./p.m.

IS THE WORKER LOSING TIME BEYOND THE DAY OF INJURY? YES _____ NO _____

NOTE: All lost time for workplace injuries/disease, must be authorized by health professional.

Attention: If the worker seeks health care or loses time at a later date, please notify the Employee Wellness and Disability Management Office.

Supervisor's Signature: _____ **Date:** _____

The personal information on this form is collected under the authority of the Workplace Safety & Insurance Act. This information will only be used to comply with the statutory reporting requirements of the Act. If you wish to review this information or require additional information concerning this collection, contact the OCDSB, WSIB Coordinator.

Instructions for Completion of Worker's Accident Report

1. The **WORKER'S ACCIDENT INFORMATION** is completed by the Injured Worker and the Supervisor and then immediately **FAXED** to the Employee Wellness and Disability Management Office, fax # (613) 596-8798. Information must be received within 24 hrs. of a work related accident.

2. If Heath Care or Lost Time is required, the Injured Worker must take this Worker's Accident Report to the treating Health Care Professional for them to complete the **FUNCTIONAL ABILITIES REPORT.**
A PHOTOCOPY OF THE WORKER'S ACCIDENT REPORT MUST REMAIN AT THE WORKSITE.

3. The completed Functional Abilities Report is **FAXED** to the Employee Wellness and Disability Management OFFICE at fax # (613) 596-8798 within 2 working days.

4. One copy of this form remains in the workplace or is sent to the Area Supervisor (Facilities).
One copy is for the worker's records.

5. If there are questions/concerns, please call Employee Wellness and Disability Management at (613) 596-8250.

THIS SECTION TO BE COMPLETED BY TREATING HEALTH PROFESSIONAL

FUNCTIONAL ABILITIES REPORT

WORKER'S NAME:_____ has authorized the treating health professional, to provide the worker, the employer, and the Workplace Safety and Insurance Board with functional abilities information. Please indicate your opinion of the worker's medical precautions. The functional abilities information allows the workplace parties to cooperate in the worker's early and safe return to work; thereby meeting the "Return to Work" obligation of the Workplace Safety and Insurance Act. Should you have any questions or concerns, contact the Ottawa-Carleton District School Board, Employee Wellness and Disability Management office (613) 596-8250.

Medical Precautions:

Worker is capable of returning to regular work immediately: Yes ☐ Or No ☐

Worker is capable of returning to modified duties as per recommended precautions: Yes ☐ Or No ☐

Area of body involved (State right or left side, if applicable): _____

Lifting: Not at all ☐ Or Not Over ☐ Kilograms

Upper Limbs: _____ Avoid sustained activity at or above shoulder level.
_____ Avoid repetitive, sustained pulling/pushing

Back: _____ Avoid sustained bending
_____ Avoid kneeling/crouching/squatting
_____ Avoid/minimize twisting and cramped quarters

Mobility: _____ Avoid static standing
_____ Avoid sustained sitting
_____ May alternate between sitting and standing as required
_____ No climbing ladders/stairs

Other: Please specify – e.g. can not operate motorized equipment, medication restriction (specify), etc.

_____

Treatment:

Does this worker require further treatment? Yes ☐ No ☐

Further treatment will be carried out by:

☐ Physician ☐ Specialist ☐ Physiotherapist ☐ Chiropractor ☐ Other _____

When is the worker to be reassessed? Date: _____

Is a complete recovery expected? Yes ☐ No ☐

Name of Health Professional: _____ Signature: _____ Date: _____

Address: _____ Phone: _____ Fax: _____

***THE COMPLETED REPORT MUST BE RETURNED TO THE OCDSB EMPLOYEE WELNESS AND DISABILITY MANAGEMENT OFFICE WITHING 2 DAYS**

NOTE TO DOCTOR: A WSIB Form 8 (Physicians First Report) needs to be submitted to WSIB.