Occupational Health & Safety Program

INCIDENT INVESTIGATION

Table of Contents

Contents

1.0 Introduction

The Incident Investigation component of the districts Health and Safety program aims:

1) To determine the immediate and basic causes of an incident, and
2) To take corrective action to eliminate or correct these causes and to reduce the potential of a future recurrence of the incident.

The intent of the investigation is not to fix blame on those involved in incidents. More importantly, the identification of immediate and basic causes, management control functions, and education resulting from the occurrence is the primary objective.

In the reporting, investigation, and analysis process, there are three (3) basic facts to remember:

- Incidents are caused;
- By identifying and eliminating causes, future incidents can realistically be prevented; and
- Unless the causes are effectively eliminated and/or additional control measures are adopted, the same incidents will likely occur again.

All near misses and incidents that have caused injury, loss of product, damage to property, or downtime must be reported immediately. An investigation will be conducted to identify the root cause(s) for high risk incidents and to recommend actions to prevent recurrence.

The investigation of an incident will be proportionate to the loss potential. As the degree of loss potential increases, so will the degree of investigation.

2.0 Scope

The incident investigation element of this program applies to all District 22 facilities and those working within them. It applies to occupational related incidents which include the following:

- An employee suffers a workplace injury
- There is potential for causing serious injury to an employee
- Property damage has occurred
- Major release of a hazardous substance

Definitions

- **Incident**

  Someone hurt, something broken, something spilled or released, something shutdown unintentionally.

- **Near Miss**

An event, whereby under slightly different circumstances, there could have been an actual incident in which a loss or injury was incurred. Sometimes referred to as a "close call".

- **Hazard**

A source of danger; a potential for loss or injury; a condition or practice with the potential to cause physical harm to a person; a loss of product; damage to property; or facility downtime.

- **Notification**

Refers to an immediate action of reporting (by the most rapid means, usually directly in person or by telephone).

- **Investigation**

Refers to a detailed review of the circumstances leading up to, and including, the event. The investigation shall be initiated as soon as practicable, and depending upon the magnitude of the event, could take weeks to complete. As well as documenting the basic and immediate causes, incident investigation requires a more in-depth review by identifying the root causes and indirect contributing factors.

- **Lost Time Incident (LTI)**
  A lost time incident (LTI) is an incident where a physician directs the injured to remain away from work longer than the day of the incident.

- **Medical Aid (MA)**
  An injury requiring treatment by a physician beyond simple first aid care but does not result in time lost from work beyond the day of the injury is classified as a Medical Aid (MA).

- **First Aid (FA)**
  A first aid is when a qualified person renders immediate treatment and the worker immediately returns to work.

3.0 Responsibilities

3.1.1 District Responsibilities

- To ensure that all employees are aware of the requirements to report incidents and injuries;
- To ensure that investigations are undertaken when required;
- To ensure that all those conducting investigations are adequately trained;
- To ensure that recommendations are followed up on.

3.1.2 Immediate Supervisor

- Provide assistance to the employee as necessary
- Preserve the scene until such time as the incident investigation is complete
- Immediately inform the District Occupational Safety Officer when made aware of any lost time, treatment beyond a first aid or any other "serious" incidents as illustrated by WorkSafeBC
- Inform the District Occupational Safety Officer of any updates to the employee's status
- Complete Form 7 Employers report of Injury or Occupational Disease and submit to the District Occupational Safety Officer
- Complete an investigation as required
- Review the incident with the employee to prevent a re-occurrence

3.1.3 Safety Officer

- Monitor that accident investigations are conducted anytime an employee injury report form is completed, monitor that the required investigation form is completed and that the investigation includes recommendations as well as corrective actions
- Where reports are incomplete or where inadequacies are noted, return the report to it's original author for further follow-up
- Provide assistance and/or conduct follow-up on reports as necessary
- Act as a resource to staff
- Assist in major investigations
- Report incidents to the appropriate agency as required

3.1.4 First Aid Attendants Responsibilities

- To treat all injuries in an appropriate manner;
- To ensure that injured workers notify their immediate supervisor or make the appropriate notifications when the injured person is unable
- To complete all reports as required.

3.1.5 Injured Persons Responsibilities

- To report all incidents and injuries;
- To cooperate with the investigation team;
- To complete all reports as required
- Keep their supervisor or the employer up to date on the status of their injury
- Cooperate with WorkSafeBC and the School District for a safe return to work in the event of lost time from work and/or medical restrictions

3.1.6 Health & Safety Committee Responsibilities

- To assist the employer with investigations when requested;
- To ensure that recommendations resulting from investigations are acted upon in a timely fashion;
- To study statistics of incidents/injuries and make recommendations to the employer.

4 First Aid Flow

First Aid Reporting Flow

Incident Occurs

⇩

REPORT TO FIRST AID ATTENDANT

⇩

Injured worker reports incident to direct supervisor

⇩

REQUIRED DOCUMENTATION

Who	What	Where	When
First Aid Attendant	First Aid Record	safety@sd22.bc.ca	24 hrs
Injured Person	Form 6A	safety@sd22.bc.ca	24 hrs

NOTE: Additional investigation may be required based on potential severity.

Send all documentation to safety@sd22.bc.ca

5 Medical Aid Flow

MEDICAL AID Reporting Flow

Incident Occurs

⇩

REPORT TO FIRST AID ATTENDANT

⇩

Injured worker reports incident to direct supervisor. IF unable to the first aid attendant will report to the workers supervisor. The supervisor will report to the workers manager . IF assistance is required the manager will contact safety.

⇩

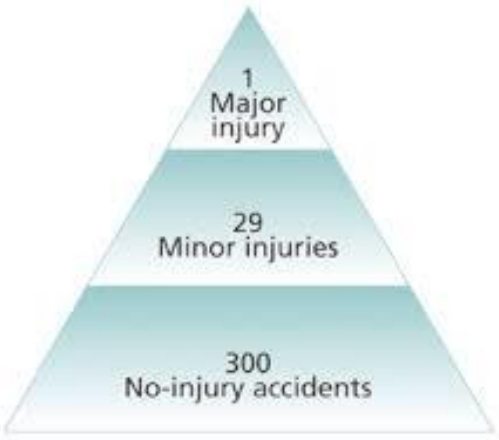
REQUIRED DOCUMENTATION

Who	What	Where	When
First Aid Attendant	First Aid Record	safety@sd22.bc.ca	24 hrs
First Aid Attendant	Physicians Assessment	Provide to Injured Person	ASAP
Injured Person	Form 6A	safety@sd22.bc.ca	24 hrs
Injured Person	Physicians Assessment	Give to Doctor	At time of visit
Supervisor	Form 7	safety@sd22.bc.ca	24 hrs
Supervisor	Employer Incident Investigation Report - Preliminary Investigation with corrective actions complete	safety@sd22.bc.ca	48 hrs
Supervisor	Employer Incident Investigation Report - Full Investigation	safety@sd22.bc.ca	20 days

6 Near miss Reporting

A **near miss** is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality or damage; in other words, a miss that was nonetheless very near. Synonymous phrases to "**near miss**" are "**close call**", or "**nearly a collision.** By reporting and investigating near miss situations we can take a proactive approach to dealing with potentially unsafe conditions.

Studies indicate for each serious result there are 29 minor and 300 near-misses which go uncorrected.



NEAR MISS REPORTING, INVESTIGATION AND APPLIED CORRECTIVE ACTIONS

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REDUCED MINOR AND MAJOR INJURY INCIDENTS

Near misses will be reported to the workers supervisor and investigated as required. The level of investigation will be dictated by probability and potential impact. The Incident / Near Miss / Hazard Id form will be used to document the event.

7 Non Injury Incidents

Will be documented on the Incident / Near Miss / Hazard Id form and investigated as required.

8 Who Should Investigate?

Investigations are to be conducted by persons knowledgeable about the type of work involved, with the participation of the employer or a representative of the employer and a worker representative, the Principal or supervisor in charge of the area and/or personnel involved. A member of the Joint Safety Committee will assist in the investigation and the Principal or the Director of Facilities will ensure that the appropriate corrective actions take place. As the investigation can be rather complex, there will be training for investigation techniques for those involved in conducting investigations.

9 Investigation procedure

1. Secure the scene to minimize the risk of any further injury. While approaching the accident scene, analyze the situation and take suitable action to prevent further deterioration.

2. Ensure the injured are cared for. Make sure that the injured workers are properly cared for before starting the investigation.

3. Keep the accident scene as undisturbed as possible. The Act provides that the scene of an accident must not be disturbed except to the extent necessary to attended to people who have been injured, to prevent further injuries or death or to protect property endangered as a result of the accident.

4. Make an accurate record of the accident scene. Photographs of the accident scene should be taken, drawings made, and measurements checked for reference in future discussions.

5. Identify and interview all witnesses separately and individually as soon as possible.

6. Record all information accurately.

7. Start the incident investigation report.

10 Corrective Action

In order to ensure that remedial action is completed in a timely manner, it is critical that these actions are listed on a Corrective Action Register or inputted into the Work Order process, and reviewed regularly for progress. As actions are completed they should be signed off. Actions that are delayed in being performed must be reviewed by management and moved up in priority accordingly.

A key person to be responsible for coordination of all corrective actions resulting from incident investigations. The key person will oversee insertion of the corrective actions into the work plan and final completion.

11 Communication

Besides ensuring that the corrective action items are promptly addressed, it is important that all workers, especially those directly involved with the incident, are informed of the results of the Incident Investigation. Effective communication to employees of incidents is one of the most important controls that can be used to prevent recurrences of events. This communication can be presented in the form of a Safety Meeting, or could be contained within an employee memo. All reports and investigations will go to the District Occupational Health and Safety Committee for review.

12 References

Workers Compensation Act – Part 3 Division 10 Accident Reporting and Investigation
Link:
http://www2.worksafebc.com/Publications/OHSRegulation/GuidelinesWorkersCompensationAct.asp?ReportID=34785http://www2.worksafebc.com/Publications/OHSRegulation/GuidelinesWorkersCompensationAct.asp?ReportID=34785

Workers Report of Injury or Occupational Disease to Employer (Form 6A)
Link: http://www.worksafebc.com/forms/assets/PDF/6a.pdf

Employers Report of Injury or Occupational Disease (Form 7)
Link: http://www.worksafebc.com/forms/assets/PDF/7.pdf

Employer Incident Investigation Report
Link: http://www.worksafebc.com/forms/assets/PDF/52E40.pdf

13 Appendix 1 – Workers Report

WORK SAFE BC

Worker's Report of Injury or Occupational Disease to Employer

▶ Submit directly to employer. Do NOT submit to WorkSafeBC.

Section 53(3) of the *Workers Compensation Act* requires that, where a worker is fit, and on request of the employer, they must provide the employer with particulars of the injury or occupational disease on a report prescribed by WorkSafeBC and supplied to the worker by the employer. This is the report prescribed.

- If requested by employer, please complete this report as it appears.
- This report should be completed by the injured worker if fit to do so. It can be completed by another individual for signature by the injured worker.
- If you need assistance with completing this form, please call WorkSafeBC Claims Call Centre at 604.231.8888 or toll-free throughout Canada at 1.888.967.5377, Monday to Friday, 8 a.m. to 6 p.m. PST.

Worker's information

WorkSafeBC claim number (if known)		Customer care number (if known)	
Worker's last name		First name	Middle initial
Date of birth (yyyy-mm-dd) - -	Personal health number (BC Services/CareCard)	Social insurance number	
Address line 1		Address line 2	
City	Province/State	Country (if not Canada)	Postal code/Zip
Home phone number (include area code)		Business phone number (include area code)	Business extension
Occupation			Gender ☐ Male ☐ Female

Employer's information

Employer's organization name			
Type of business (if known)		Operating location (if known)	
Address line 1		Address line 2	
City	Province/State	Country (if not Canada)	Postal code/Zip
Employer's contact name		Employer's phone number (include area code)	Extension

Incident information

1. Date and time of incident (yyyy-mm-dd) ☐ a.m. ☐ p.m. **OR**	2. Period of exposure resulting in occupational disease (yyyy-mm-dd) From To
3. Date and time my injury or disease was first reported to my employer (yyyy-mm-dd) ☐ a.m. ☐ p.m.	My injury or disease was first reported to (please check one) ☐ First aid ☐ Supervisor ☐ Office ☐ Other (specify)

WORK SAFE BC

Worker's Report of Injury or Occupational Disease to Employer

Worker's last name	First name	Middle initial	WorkSafeBC claim number
	Social insurance number	Personal health number (BC Services card/CareCard)	

Incident information (continued)

4. Name of person reported to

5. Did you receive first aid? ☐ Yes ☐ No ▶

6. Date of first aid (yyyy-mm-dd)

7. Name of first aid attendant

8. Did you go to the hospital, a medical clinic, or see a physician? ☐ Yes ☐ No ▶

9. If yes, name of physician or provider (if known)

10. Address of physician or provider (if known)

11. Are you aware of any recent pain or disability in the area of your reported injury? ☐ Yes ☐ No ▶

If yes, please explain

12. Was protective equipment being used? ☐ Yes ☐ No

13. Were there any witnesses? ☐ Yes ☐ No

14. The supervisor in charge at the time of my injury was

15. Describe how the incident happened

16. Describe the injury in detail (what part of the body was injured)

17. Side of body injured ☐ Left ☐ Right ☐ Both ☐ Not applicable

WORK SAFE BC

Worker's Report of Injury or Occupational Disease to Employer

Worker's last name	First name	Middle initial	WorkSafeBC claim number

Social insurance number	Personal health number (BC Services card/CareCard)

Incident information (continued)

18. Describe the work incident location (address, city, province) and where incident occurred (e.g., shop floor, lunchroom, parking lot)

19. Contributing factors — select **at least one**, and as many as applicable

- ☐ Lifting_____ ☐ lb ☐ kg
- ☐ Overexertion
- ☐ Repetitive (activity repeated over and over again)
- ☐ Slip or trip
- ☐ Twist
- ☐ Fall
- ☐ Struck
- ☐ Crush
- ☐ Sharp edge
- ☐ Fire or explosion
- ☐ Harmful substance in the work environment
- ☐ Animal bite
- ☐ Assault
- ☐ Motor vehicle accident
- ☐ Unsure/other (please explain below)

20. Did you or will you miss any time from work beyond the date of injury or exposure?

☐ Yes ☐ No

Signature and report date

21. Worker's signature	22. Date of report (yyyy-mm-dd)

Additional information

The BC Legislature provides impartial advisers on all workers' compensation matters. The Workers' Advisers Office (WAO) provides free advice and assistance to workers and their dependants on disagreements they may have with WorkSafeBC decisions. WAO operates independently of WorkSafeBC. They have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/ or by telephone: Richmond 604.713.0360, toll-free 1.800.663.4261; Victoria 250.952.4393, toll-free 1.800.661.4066; Kelowna 250.717.2096, toll-free 1.800.663.6695.

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.

14.0 Appendix 2 - Supervisors Documentation for medical aid

WORK SAFE BC

RESET

Employer's Report of Injury or Occupational Disease

As an employer, the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

1. **Online — The quickest and easiest option**: The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to **worksafebc.com** and select "Report injury or illness."
2. **Fillable PDF form**: Type in your details online, print the form, and submit it by **fax** or **mail**. Go to **worksafebc.com** and select "Report injury or illness."
3. **Paper form**: Clearly **print** details, sign the form, and submit it by **fax** or **mail**.
   Fax: 604.233.9777 in Greater Vancouver or **toll-free** within BC at **1.888.922.8807**
   Mail: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

Employer information

				WorkSafeBC claim number (if known)
Employer's name (as registered with WorkSafeBC)				Type of business
WorkSafeBC account number		Classification unit number		Operating location number
Employer address line 1 (mailing)		Employer contact last name		First name
Employer address line 2 (mailing)		Employer contact telephone (and area code)	Extension	Employer contact fax (and area code)
City	Province/state	Employer payroll contact last name		First name
Country (if not Canada)	Postal code/zip	Employer payroll contact telephone (and area code)	Extension	Employer payroll contact fax (and area code)

Worker information

Worker last name	First name	Middle initial	Gender ☐ M ☐ F
Date of birth (yyyy-mm-dd)	Home phone number (include area code)	Social insurance number	
Address line 1		Address line 2	
City	Province/state	Country (if not Canada)	Postal code/zip

1. What is the worker's occupation?	2. Has the worker been employed by this firm for less than 12 months? ☐ Yes ☐ No	3. If yes, start date (yyyy-mm-dd)

4. At the time of injury, was the worker (check all that apply)

☐ Permanent	☐ Apprentice	☐ Self-employed	☐ Casual
☐ Temporary	☐ Volunteer	☐ Principal/partner or relative of employer	☐ Other (specify)
☐ Full time	☐ Student	☐ Fisher	
☐ Part time	☐ New entrant to workforce	☐ Hired on a contract basis	

Incident information

5. Date of incident (yyyy-mm-dd)	Time of incident (hh:mm) ☐ am ☐ pm **OR**	6. Period of exposure resulting in occupational disease (yyyy-mm-dd) From To
7. Did worker report injury or exposure to employer? ☐ Yes ☐ No ▶	8. The injury or disease was first reported to employer on (yyyy-mm-dd)	(please check one) To: ☐ First aid ☐ Supervisor ☐ Office ☐ Other (specify)
9. Name of person reported to		
10. Describe how the incident happened	11. Describe the injury in detail (what part of the body was injured)	
	12. Side of body injured ☐ Left ☐ Right ☐ Both ☐ Not applicable	
13. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)		
14. Did the injury(ies) or exposure result from a specific incident? ☐ Yes ☐ No		

WORK SAFE BC

Employer's Report of Injury or Occupational Disease

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

Worker last name	First name	Middle initial	WorkSafeBC claim number (if known)

Social insurance number	Personal health number (CareCard)	Date of incident (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)
		- -	- -

15. Contributing factors — select **at least one**, and as many as applicable

- ☐ Lifting ☐ lb ☐ kg
- ☐ Overexertion
- ☐ Repetitive (activity repeated over and over again)
- ☐ Slip or trip
- ☐ Twist
- ☐ Fall
- ☐ Struck
- ☐ Crush
- ☐ Sharp edge
- ☐ Fire or explosion
- ☐ Harmful substances in the work environment
- ☐ Animal bite
- ☐ Assault
- ☐ Motor vehicle accident
- ☐ Unsure/other (please explain below)

16. Were there any witnesses? ☐ Yes ☐ No	17. Did the incident occur in British Columbia? ☐ Yes ☐ No
18. Were the worker's actions at time of injury for the purpose of your business? ☐ Yes ☐ No	19. Did the incident occur on employer's premises or an authorized worksite? ☐ Yes ☐ No
20. Did the incident happen during the worker's normal shift? ☐ Yes ☐ No	21. Was the worker performing their regular duties at the time of the incident? ☐ Yes ☐ No
22. Did the worker receive first aid? ☐ Yes ☐ No Date (yyyy-mm-dd) ▶	If yes, please provide first aid attendant name (if known)
23. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner? ☐ Yes ☐ No Date (yyyy-mm-dd) ▶	If yes, please provide provider name (if known)
If yes, please provide provider address (if known)	
24. Are you aware of any recent pain or disability in the area of the worker's reported injury? ☐ Yes ☐ No	
25. Do you have any objections to the claim being allowed? ☐ Yes ☐ No ▶	If yes, please explain

Wage information

26. Did the worker miss any time from work beyond the date of injury or exposure? ☐ Yes ☐ No

If no work was missed and **no change** to duties/pay, proceed to bottom of page to sign, date, and submit this report.
If **work was missed** or if duties/pay have been **modified**, please answer **all** questions on this form.

27. Provide the **base salary** amount for this employment position at the time of injury
$ ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

28. Does worker receive other amounts of compensation in addition to **base salary**? ☐ Yes ☐ No
Does worker receive vacation pay on every cheque? ☐ Yes ☐ No
If yes, vacation pay _____%

Please select check boxes for any of the following amounts worker receives in addition to **base salary** AND provide the amount for each:
- ☐ Tips and gratuities $_____ ☐ Room and board $_____
- ☐ Shift differential $_____ ☐ Other $_____
- ☐ Overtime $_____

29. If worker is disabled from work, will you continue to pay:
Base salary? ☐ Yes ☐ No
Other amounts of compensation in addition to **base salary**? ☐ Yes ☐ No
Will worker receive vacation pay on every cheque? ☐ Yes ☐ No
If yes, vacation pay _____%

Please select check boxes for any of the following amounts worker will continue to receive in addition to **base salary** AND provide the amount for each:
- ☐ Tips and gratuities $_____ ☐ Room and board $_____
- ☐ Shift differential $_____ ☐ Other $_____
- ☐ Overtime $_____

30. Provide the amount of **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure
$ ☐ 3 months ☐ 12 weeks

31. Does the worker have a fixed-shift rotation? ☐ Yes ☐ No

32. If no, please explain

33. If yes, show the normal work week by entering the paid hours

Sun	Mon	Tues	Wed	Thu	Fri	Sat

34. Did the worker continue to work past day of injury? ☐ Yes ☐ No	35. Last day worked (yyyy-mm-dd)	
36. Number of hours scheduled to work on last day worked	37. Number of hours worked on last day	38. Number of hours paid by employer on last day worked

WORK SAFE BC

Employer's Report of Injury or Occupational Disease

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

Worker last name	First name	Middle initial	WorkSafeBC claim number (if known)

Social insurance number	Personal health number (CareCard)	Date of incident (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)
		- -	- -

Return-to-work information

39. Has the worker returned to work?
☐ Yes ☐ No

40. If **Yes**: Date (yyyy-mm-dd)
Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed? ☐ Yes ☐ No

41. If **No**: Do you have any modified or transitional duties available?	42. If yes, please describe modified or transitional duties
☐ Yes ☐ No Have the modified or transitional duties been offered to the worker? ▶ ☐ Yes ☐ No	

Signature and report date

43. Employer signature	44. Employer title	45. Date of report (yyyy-mm-dd)

For assistance, please call our Claims Call Centre at 604.231.8888 or toll-free within Canada at 1.888.967.5377, M–F, 8:00 a.m. to 6:00 p.m.

Please note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns. **Impartial advice on WorkSafeBC claims** — To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their website at www.labour.gov.bc.ca/eao/.

Lower Mainland
604.713.0303 (Richmond)
Toll-free within Canada 1.800.925.2233

Abbotsford, Kamloops, Kelowna, Nanaimo, Trail, Prince George, Victoria
Toll-free within Canada 1.800.925.2233

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15.0 Appendix 3 - Employer Incident Investigation Report

Employer Incident Investigation Report (EIIR)

Please refer to the companion quick guide for assistance completing the investigation and this form.

1. Employer's information

Employer's name (legal name and trade name)		
WorkSafeBC account number	Operating location number	
Employer's head office address		
City	Province	Postal code
Employer's representative's name		Phone number (include area code)
Email address		

2. Injured persons

Last name	First name	Job title
a)		
b)		
c)		
d)		

3. Place, date, and time of incident

Location where incident occurred (street address or GPS coordinates)		
City (nearest)	Province	Postal code
Date of incident (yyyy-mm-dd)	Time of incident	☐ a.m. ☐ p.m.

4. Type of occurrence (select all that apply)

- ☐ Death of a worker
- ☐ Serious injury to a worker
- ☐ Major structural failure or collapse
- ☐ Major release of hazardous substance
- ☐ Blasting accident causing personal injury
- ☐ Dangerous incident involving explosives other than blasting incident
- ☐ Diving incident, as defined by regulation
- ☐ Incident of fire or explosion with potential for serious injury
- ☐ Minor injury or no injury but had potential for causing serious injury
- ☐ Injury requiring medical treatment beyond first aid

An incident investigation report is NOT required under the *Workers Compensation Act* if none of the above applies or if this incident is a vehicle accident occurring on a public street or highway.

5. Report type (select all that apply)

If this is a **revised version of a previous report**, please check here ☐

☐ Preliminary Investigation Report Report date (yyyy-mm-dd) Only provide to a WorkSafeBC officer **if requested** Officer's name	☐ Interim Corrective Action Report Report date (yyyy-mm-dd)	☐ **Full Investigation Report** Report date (yyyy-mm-dd) **Must be provided to WorkSafeBC within 30 days* Fax 1.866.240.1434** Date sent (yyyy-mm-dd)	☐ Full Corrective Action Report Report date (yyyy-mm-dd)

Employer Incident Investigation Report (EIIR)

6. Witnesses

Last name	First name	Job title
a)		
b)		
c)		

7. Other persons whose presence might be necessary for proper investigation

Last name	First name	Job title
a)		
b)		

8. Sequence of events that preceded the incident

Required in Preliminary Report. Update in Full Report if necessary. Describe events earlier that day or even in previous years that led up to the incident. Examples may include events such as training given or changes in equipment, procedures, or company management.

9. Unsafe conditions, acts, or procedures that significantly contributed to the incident

Required in all reports. Describe anything, or the absence of anything, that contributed to the hazard such as poor housekeeping or poor visibility, using equipment without guards, or the lack of safe work procedures.

10. Nature of the serious injury (optional — complete only if there has been an injury)

- ☐ Life threatening or resulting in loss of consciousness
- ☐ Major broken bones in head, spine, pelvis, arms, or legs
- ☐ Major crush injuries
- ☐ Major cut with severe bleeding
- ☐ Amputation of arm, leg, or large part of hand or foot
- ☐ Major penetrating injuries to eye, head, or body
- ☐ Severe (third-degree) burns
- ☐ Punctured lung or other serious respiratory condition
- ☐ Injury to internal organ or internal bleeding
- ☐ Injury likely to result in loss of sight, hearing, or touch
- ☐ Injury requiring CPR or other critical intervention
- ☐ Diving illness such as decompression sickness or near drowning
- ☐ Serious chemical or heat/cold stress exposure
- ☐ Other (specify)

Employer Incident Investigation Report (EIIR)

11. Brief description of the incident

Required in Preliminary Report. Briefly, summarize the sequence of events, the unsafe factors, and the resulting injury, if any.

12. Corrective actions identified and taken to prevent recurrence of similar incidents

Action (Required in Preliminary Report and Interim Corrective Action Report. Update in Full Report, if necessary.)	**Action assigned to** (name and job title)	**Expected completion date** (yyyy-mm-dd)	**Completed date** (yyyy-mm-dd)
a)			
b)			
c)			
d)			
e)			

13. Explanation of blank areas on this Preliminary Report, if any

If there are blank areas, describe the circumstances beyond your control that explain this lack of information.

14. Persons who carried out or participated in the preliminary investigation

Representative	**Name**	**Job title**	**Signature** (optional)	**Date signed** (yyyy-mm-dd)
Employer representative (required)				
Worker representative (required)				
Other				
Other				

End of report

Completing all the sections above satisfies the requirements for a Preliminary Investigation Report and an Interim Corrective Action Report.

Note: If this was a simple investigation and **all needed corrective actions have been completed within 48 hours**, the Preliminary and Full Investigation portions of the report can be completed at the same time. If so, you can check both the Preliminary Investigation Report and the Full Investigation Report boxes in section 5 on page 1. As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.

Employer Incident Investigation Report (EIIR)

15. Determination of causes of incident

Required in Full Report. Analyze the facts and circumstances of the incident to identify underlying factors that led to the incident. Underlying factors include factors that made the unsafe conditions, acts, or procedures in the Preliminary Report possible. Update items from section 9, if needed.

16. Full description of the incident

Required in Full Report. Use the brief description from the Preliminary Report and update it, if necessary.

17. Additional corrective actions necessary to prevent recurrence of similar incidents

Additional corrective action (Required in Full Report and Full Corrective Action Report.)	**Action assigned to** (name and job title)	**Expected completion date** (yyyy-mm-dd)	**Completed date** (yyyy-mm-dd)
a)			
b)			
c)			
d)			

18. Persons who carried out or participated in the full investigation

Representative	**Name**	**Job title**	**Signature** (optional)	**Date signed** (yyyy-mm-dd)
Employer representative (required)				
Worker representative (required)				
Other				

19. Other relevant workplace parties

Company name	**Contact person**	**Contact number or email address**
a)		

End of report

Completing all the sections above satisfies the requirements for a Full Investigation Report and a Full Corrective Action Report.

Employers are required to submit **full** investigation reports to WorkSafeBC **within 30 days* of the incident.** Reports may be submitted by fax to 604.276.3247 (Greater Vancouver), toll-free fax 1.866.240.1434, or by mail to PO Box 5350, Stn Terminal, Vancouver BC V6B 5L5. Do **NOT** submit a preliminary report unless you have been so directed by a WorkSafeBC officer.

* Employers can request an extension from a WorkSafeBC officer, **if the full investigation cannot be completed within 30 days.**

As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.

16.0 Appendix 4 - First Aid Attendant documentation

WORKSAFE BC

First Aid Record

RESET

This record must be kept by the employer for three (3) years. This form must be kept at the employer's workplace. Do **NOT** submit to WorkSafeBC.

Sequence number

Name	Occupation
Date of injury or illness (yyyy-mm-dd)	Time of injury or illness (hh:mm) ☐ a.m. ☐ p.m.
Initial reporting date and time (yyyy-mm-dd) (hh:mm) ☐ a.m. ☐ p.m.	Follow-up report date and time (yyyy-mm-dd) (hh:mm) ☐ a.m. ☐ p.m.
Initial report sequence number	Subsequent report sequence number(s)

Description of how the injury, exposure, or illness occurred (What happened?)

Description of the nature of the injury, exposure, or illness (What you see — signs and symptoms)

Description of the treatment given (What did you do?)

Name of witnesses

1.	2.

Arrangement made relating to the worker (return to work/medical aid/ambulance/follow-up)

Provided worker handout ☐ Yes ☐ No Alternate duty options were discussed ☐ Yes ☐ No	A form to assist in return to work and follow-up was sent with the worker to medical aid ☐ Yes ☐ No
First aid attendant's name (please print)	First aid attendant's signature
Patient's signature	

LETTER TO WORKER

Date

Dear

We are sorry to hear of your recent injury. We are providing you with our return-to-work information package that includes:

1. A **Letter to Physician** explaining our injury management program
2. A **Stay-at-Work/Return-to-Work Planning Form** for your physician to provide information regarding any limitations for your return-to-work plan.

Please take this information to your physician on your first visit, and have him/her complete the *Stay-at-Work/Return-to-Work Planning* form.

After your appointment, please return to the worksite with your completed form. Your supervisor will meet with you and develop your return-to-work plan with any recommended modifications to your job duties.

Should you have any questions or concerns, please call (employer contact) at (phone number).

Sincerely,

LETTER TO PHYSICIAN

Date

Employee’s name

Dear Dr.

As part of our stay-at-work/return-to-work program we have ***modified or alternate duties*** available for our employees.

Your recommendations regarding any temporary functional limitations your patient may have will assist us with providing the most suitable work accommodations during your patient’s recovery.

After examining (worker's name) please complete the *Stay-at-Work/Return-to-Work Planning* form and give it to your patient to return to us.

If you have any questions and/or concerns, please contact me at (phone number).

Should there be a cost associated with completing the *Stay-at-Work/Return-to-Work Planning* form please send an invoice to _____.

(employer’s contact)

Sincerely,

(employer)

17.0 Appendix 5 - Incident/Hazard ID/Near Miss

Incident / Hazard Id / Near Miss Report

Name of person reporting:	**Date reported:**	**Time:**
General location (school, facility):	**Specific location (room #, area):**	
Incident ☐ **Hazard Id** ☐ **Near Miss** ☐		
Description of Incident, Hazard or Near miss		
Immediate Action Taken:		
Basic Cause(s)	**Contributory Cause(s)**	
Recommended Corrective Actions :		

Supervisor to complete:

Corrective action	Assigned to	Target Completion Date

Comments:

Are corrective actions complete? YES ☐ NO ☐

Committee Member's Signature	**Date:**
Supervisor's Signature:	**Date:**

Send to: safety@sd22.bc.ca

17.0 Appendix 6 - Additional tools

WITNESS STATEMENT

Witness Name:	**School Name:**
Department:	**Location:**
Date:	**Time:**
Address:	**City:**
Postal Code:	**Phone: ( )**
Witness Signature:	
If more space is required, please use reverse side and/or obtain another form from the investigator.	

Il

Claim Number				
On Street or Road Building				Show North by Arrow ○ Scale
At Intersection				
In Location				
Hour **Month**	**Day**	**20____**	**Reported by**	

Indicate on this diagram what happened:

Please see reverse side

SKETCHING CHECKLIST

By eliminating irrelevant details and adding measurements, you can often sketch a scene more clearly than you can photograph it.
The following points will make sketching for Incident maps easy without sacrificing accuracy:

1. Use squared paper. Let each square represent a fixed distance such as a foot and write the scale at the top of the sketch.
2. Use a strip of squared paper to measure diagonals on the sketch.
3. Locate each important object with a rough outline.
4. Label large objects inside their outline. Label small objects outside their outline with an arrow to the object; the arrow should just touch the object.
5. For maps with a lot of detail, use a sketch log. Use double letters to identify reference points and single letters to identify items of evidence.
6. Indicate distances of movable objects from at least two fixed points. Logs for detailed maps have columns for measurement data.
7. Include a north arrow in each sketch.
8. Mark camera positions by a letter inside a circle. Later the appropriate letter should be used on each print.
9. Identify the sketches with a label, data box or on the back just as you would a photograph

SEQUENCE OF EVENTS RECORD

Date	Time	Description of Action Taken and Persons Involved	Initials