

## TOWNSHIP OF WOLLASTON

### xiv. INJURY / ACCIDENT / DAMAGE INVESTIGATION POLICY

Date Approved by Council: August 10, 2020

#### **PURPOSE:**

To promote a safe working environment, the Township of Wollaston will follow this policy to investigate any injury / accident / or damage reports.

#### **SCOPE:**

Supervisors/Department Heads shall investigate all injury / accident / damage reports in order to determine the cause and what corrective actions need to be implemented to prevent a recurrence.

#### **RESPONSIBILITIES:**

All employees, volunteers, students, Council Members shall promptly report all incidents of injury / accident or damage to their immediate supervisor. The appropriate forms are to be filled out.

Supervisors / Department Heads shall conduct initial investigations using the **INJURY / ACCIDENT / DAMAGE INVESTIGATION form** which is to be forwarded to the Clerk / Administrator.

WSIB Form 7 must be completed and submitted within three days upon learning of your reporting requirements.

#### **POLICY:**

The following types of injury/accidents/damage shall be fully investigated

1. Workplace injuries that require health care.
2. Accidents that cause damage to non-municipally owned property.
3. Accidents that involve other vehicles. Must also complete the **VEHICLE ACCIDENT REPORT FORM**
4. Damage to equipment that is not considered normal usage
5. Incidents in which municipal vehicle or equipment have left the travelled portion of the roadway and require assistance
6. Damage to municipal property requiring repairs or consultations from outside resources
7. Near miss incidents that could have resulted in injury or substantial damage
8. All incidents that, by regulation, must be reported to the Ministry of Labour, WSIB or other regulatory agencies.

Injuries that require health care also require WSIB form 7.

Health care is defined as follows: Services provided at hospital or health care facility, services provided by Chiropractor, Physiotherapist, Nurse or Dentist.

**WSIB Form 7** is also required if, as the result of a workplace injury, the worker is absent from regular work, earns less than regular pay (working partial hours) worker required modified work for more than seven days, worker has sustained needle prick injury, and if dentures or glasses have been damaged while being worn in a work related accident. **See: Workplace Safety Insurance Board (WSIB) Reporting Requirements Policy.**

**TOWNSHIP OF WOLLASTON**  
**INJURY / ACCIDENT / DAMAGE INVESTIGATION FORM**

Last Name:	First Name:	Occupation / Job Title:	Yrs. Experience in Occupation
Full Address:			
City/Town:			Postal Code:
Investigator Name:	Date of Occurrence:	Time:	
Location:	Date Reported:	Time:	
<b>Please circle:</b> Injury      Vehicle Accident      Near Miss      Equipment Damage      Property Damage			
Describe what happened and if applicable describe injury. Attach an accident diagram if appropriate.			
Was First Aid Required? Yes ___ No ___ was Health Care required? Yes ___ No ___ If yes completed WSIB Form 7 Has worker returned to work? Yes ___ No ___ Was the worker working overtime? Yes ___ No ___ For accident, property damage, or equipment damage has insurance company been notified? Yes ___ No ___ If no please give reason:			
<b>Part of the body injured (indicate "R" for right side or "L" for Left side where applicable)</b>			
Head	Lower Back	Hand/Fingers	Ankle/Foot
Eye	Upper Arm	Hip	Lower Leg
Neck	Elbow	Upper Leg	Upper Back
Shoulder	Lower Arm	Knee	Wrist
Other			
<b>Type of Accident / Injury</b>			
✓ Check off Statements that best describe the Accident / Injury			
Repetitive Strain	Slip / Fall	Equipment	
Acute Strain (lifting/pulling/carrying)	Vehicle	Caught in/under/between	
Client/Employee action	Struck, contacted by/with/against	Cut/Bruise	
Other: (explain)			
<b>Witnesses</b>			
Name		Address	
Telephone		Interviewed d/m/y	
Name		Address	
Telephone		Interviewed d/m/y	
Name		Address	
Telephone		Interviewed d/m/y	
<b>Remember to attach all witness statements</b>			

**CAUSES: Check all that are applicable**

Conditions	Practices
Congestion or restricted action	Improper body position/posture
Poor housekeeping; disorderly workplace	Tasks not varied/micro breaks not taken
Slip/trip hazards	Unnecessary rushing
Lack of or inappropriate furniture / equipment	Improper Lifting
Design or arrangement of furniture / equipment	Unsafe loading / placement
Defective furniture / tools / equipment or materials	Using defective equipment
Inadequate or excessive illumination	Using equipment improperly
Inadequate ventilation	Altering or modifying equipment
Excessive noise	Not using personal protective equipment or failing to use it properly
Inadequate or improper protective equipment	Not following appropriate procedures
Fire and explosion hazards	Inappropriate conduct
Inadequate warning systems	Hazardous Personal attire
Adverse weather	Other: Explain
Other: Explain	

What are the reasons for the existence of these practices and/or conditions?

**Prevention / Corrective Action**

Actions to prevent recurrence. Check those actions taken to prevent recurrence. Make with (P) other corrective actions decided upon or planned but not yet carried out. More than one item may apply:

Training / instruction of person involved	Request ergonomic assessment
Improve work procedures	Request environmental assessment
Inform staff / managers of safe work procedures	Correction of work area
Perform job safely analysis	Recommend development / improvement to training / OHS program
Inform staff / managers of hazard and how to protect themselves	Reassess work standards
Notify appropriate individuals	Reassignment of person
Improve engineering / design	Improve housekeeping
Improve inspection procedures	Other Describe
Tools, equipment, furniture repair or replacement	Is discipline recommended Yes      No If yes follow current discipline policy

Remember that ALL corrective or discipline action must be documented

Describe actions taken:

**Investigated by:**

Manager Signature	Name (print)	Date:
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Review By:

Signature:	Name (print)	Date
	Job Title:	

TOWNSHIP OF WOLLASTON  
WITNESS STATEMENT FORM

Date of Injury / Accident / Damage:	
Name of Witness:	
Date:	
Name of Interviewer:	
Details of Interview: Use additional sheets of paper if required	
Signature of Witness:	
Signature of Interviewer:	