ONA’s Investigation Guide to Fatality, Critical Injury, Illness, Accident, and Exposure

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The Ontario Nurses’ Association (ONA) is the union representing 68,000 front-line registered nurses and health-care professionals, as well as more than 18,000 nursing student affiliates providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

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Introduction

The goal of this booklet is to assist ONA members in investigating workplace accidents, fatalities and critical injuries, illnesses and occupational illnesses/exposures. It also aims to help clarify the important role that Joint Health and Safety Committees (JHSCs) and health and safety representatives (in workplaces with six to 19 workers) play in terms of these investigations.

The booklet has been created to accompany the ONA Witness Form for Fatality, Critical Injury, Accident, and Exposure and the ONA Investigation Form for Fatality, Critical Injury, Illness, Accident, and Exposure, which contains a list of questions that may be used or adapted to assist you in questioning witnesses.

The booklet is divided into three sections:

- Purpose of an Investigation for Fatality, Critical Injury, Illness, Accident, or Exposure
- Conducting an Investigation.

Terminology

It is important to note that this document uses the term health and safety representatives as defined under the OHSA. Under the OHSA, workplaces with six to 19 workers have a health and safety representative; they are not required to have JHSCs. The OSHA requires that workplaces with 20 workers or more must have JHSCs.
Purpose of an Investigation for Fatality, Critical Injury, Illness, Accident, or Exposure

A good investigation for fatality, critical injury, illness, accident, or exposure should always try to answer the “five Ws” and one “H:” who, what, where, when, why and how. The ONA Investigation Form for Fatality, Critical Injury, Illness, Accident, and Exposure, offers a systematic approach to investigating that ensures information is gathered in a comprehensive way. The purpose of the investigation is to determine the root cause(s) (often referred to as root and contributing causes), and correct/resolve them so no other worker is at risk of a similar fatality, critical injury, illness, accident, and exposure. This is also often referred to in the Health Care Residential Facilities Regulation and Industrial Establishments Regulation (Section 5) under the OHSA as the “Steps to Prevent a Recurrence.”

You have the legal right to investigate a fatal or critical injury

Critical injury is defined in a special regulation under the OHSA (Reference: Regulation 834 “Critical Injury – Defined” of the OHSA):

"Critically injured" means an injury of a serious nature that:

a) Places life in jeopardy.
b) Produces unconsciousness.
c) Results in 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.
g) Causes the loss of sight in an eye. RRO 1990, Reg. 834, s. 1.

JHSCs also have the right to investigate any fatal or critical injury/occupational illness (e.g. violence, SARS, COVID-19) and inspect the place where the accident occurred and any machine device or thing. During the SARS outbreak, the Ministry of Labour, Training and Skills Development (MLTSD) did confirm that probable SARS cases were critical injuries, even though they were also considered to be an occupational illness. One of our Bargaining Unit Presidents and JHSC members investigated the fatality of an ONA member who died from SARS (under Section 9 (31) of the OHSA). Therefore, when JHSCs have been notified of workers’ critical illnesses or fatalities, such as probable SARS or COVID-19, they should immediately initiate their critical injury or fatality investigation and inspection as per Section 9(31) of the OHSA.

Health and safety representatives, in workplaces with six to 19 workers, have the power to inspect the place where the accident occurred, and any machine, device or thing, and to report their findings in writing to the MLTSD Inspector under Section 8 (14).

It is ONA’s position, that “critically ill” or a fatality includes any illness or disease, including any occupational illness or infectious disease, which caused death or could place life in jeopardy.
Key Concepts in the *Occupational Health and Safety Act*

For more detailed information on worker and employer responsibility under the act, please see the *OHSA, Occupational Health and Safety: A Guide for ONA Members*, *Workplace Violence and Harassment: A Guide for ONA Members*, the MLTSD website and your collective agreement.

**Duty of employer to notify of death or critical injury/illness**

Where a **person** is killed or critically injured from any cause at a workplace, the employer must notify the MLTSD, the JHSC, the health and safety representative and trade union immediately and in writing within 48 hours (reference: Section 51(1) of the *OHSA*).

**Duty of employer to notify of other injuries/illnesses**

If a **person** is disabled from performing their usual work or requires medical attention because of an accident, explosion or fire or incident of workplace violence at a workplace, but no person dies or is critically injured because of that occurrence, the employer will, within four days of the occurrence, give written notice of the occurrence to the JHSC, the health and safety representative and the trade union (reference: Section 52(1) of the *OHSA*.

The employer’s obligation to provide notice is not necessarily limited to only injuries of workers. If, for instance, a patient or visitor was injured, and there is a nexus to the workplace that could also have put a worker at risk of injury/illness, the employer has an obligation to report that incident as well. For instance, it is our position that if a resident or patient gets COVID-19 in the workplace and dies, this is a reportable fatality to the JHSC, trade union and the MLTSD.

If an employer is advised by or on behalf of a worker that the worker has an occupational illness or that a claim in respect of an occupational illness has been filed with the Workplace Safety and Insurance Board (WSIB) by or on behalf of the worker, the employer will give notice in writing, within four days of being so advised, to the JHSC or the health and safety representative and the trade union (reference: Section 52(2) of the *OHSA*.

The MLTSD’s Section 21 Committee for Health Care has also developed a Guidance note on “Occupational Injury and illness Reporting Requirements” that may be of assistance. All Section 21 Guidance Notes are housed on the Public Services Health & Safety Association (PSHSA) website at [https://www.pshsa.ca/sectors-priorities/health-community-service](https://www.pshsa.ca/sectors-priorities/health-community-service).

You can also access the reporting requirements here: [https://www.pshsa.ca/training/free-training/reporting-requirements-under-the-oh-s-act](https://www.pshsa.ca/training/free-training/reporting-requirements-under-the-oh-s-act)
Right to conduct a fatal or critical injury/illness investigation

The members of a committee who represent workers shall designate one or more such members to investigate cases where a worker is killed or critically injured at a workplace from any cause and one of those members may, subject to subsection 51 (2), inspect the place where the accident occurred and any machine, device or thing, and shall report their findings to a Director and to the Committee. (Reference: Section 9(31) of the OHSA)

Section 8 (14) of the OHSA says, “Where a person is killed or critically injured at a workplace from any cause, the health and safety representative may, subject to subsection 51(2), inspect the place where the accident occurred and any machine, device or thing, and shall report their findings in writing to a Director.”

This means that for even smaller workplaces, the health and safety representative may inspect the place where the fatality or critical injury/illness occurred to a person (e.g., patient or resident) (i.e., not only a worker if the workplace caused the fatality or critical injury/illness) and allows them to also inspect any machine, device or thing (e.g., personal protective equipment, personal panic alarms linked to security with GPS/wireless type locating ability).

The JHSC worker-designated members or the health and safety representatives (in workplaces with six to 19 workers) may decide to include a management representative in the investigation, but are not required to do so. It should be noted in the JHSC’s terms of reference, which each committee should have established, that Section 9(31) of the OHSA states that a JHSC worker member has the right to investigate fatalities and critical injuries/illnesses. Where possible, try to include in the terms of reference the right of a worker member of the JHSC to also conduct other accident/illness investigations. This was one of the recommendations from Phase 1 of the Workplace Violence Prevention in Healthcare Leadership Table that both the Minister of Labour and Minister of Health endorsed.

Investigation of other injuries and near misses

Every “near miss” in health and safety statistically moves your institution toward a serious injury. So if you are not investigating accidents and incidents before they become critical, you are missing an opportunity to solve a minor problem before it becomes a serious problem. Committees should identify types of incidents/trends that would be beneficial to investigate and attempt to secure the right to do so. It should be noted, however, that JHSCs and health and safety representatives do not have an explicit legal right to investigate minor incidents under the OHSA or incidents that do not meet the definition of a critical injury or a fatality.

A serious incident occurred years ago at Guelph General, where a patient threatened workers with what everyone believed to be a real gun. Luckily, because of quick thinking and well-trained security guards, the patient was disarmed and detained. Under the OHSA, because there was no fatality or serious injury first, as required in the Critical Injury Regulation, the critical injury definition of “places life in jeopardy” would not then apply to allow the worker designated members of the JHSC to conduct a critical injury investigation. However, given the serious nature of this incident, the employer did investigate in consultation with the JHSC.
Employer response to written recommendations

Accidents and injuries should be investigated to determine all causes/contributing causes/gaps and develop measures, procedures, training etc. to prevent recurrences. JHSCs and health and safety representatives should use their findings to develop written recommendations to submit to the employer.

An employer who receives written recommendations from a health and safety representative or a JHSC must respond in writing within 21 days. A response of an employer will contain a timetable for implementing the recommendations with which the employer agrees and provide reasons why the employer disagrees with any recommendations that the employer does not accept (reference: Sections 8(12) and 9(21) of the OHSA.

Unresolved health and safety issues

If the JHSC cannot agree to put the recommendations regarding what is believed to be a violation of the OHSA and/or hazardous condition(s) in writing after good faith attempt to do so, the worker co-chair now has the right under Section 9 (19.1) to submit those recommendations on their own. Either way if the employer refuses to correct the suspected violation and/or hazardous condition, the worker co-chair or any member of the JHSC or the health and safety representative should immediately call the MLTSD, advising them that there is an unresolved health and safety issue that requires their attention.
Conducting an Investigation

Fatality, Critical injury, illness, accident, and exposure causes

Direct Causes

The direct cause of an injury/illness is often easily apparent. If a worker comes in contact with the SARS or COVID-19 virus, or if a ceiling lift falls on a worker, or a patient assaults a worker, these events can be clearly labelled direct causes of an injury/illness or fatality. It is important to remember that the direct cause of an injury/illness or fatality only explains how the injury/illness or fatality happened, not why.

Indirect Causes

The indirect cause of an injury/illness or fatality helps to answer the question of why the fatality, injury, illness, and exposure happened. Inadequate initial or ongoing training (e.g., lack of adequate hands-on training in self-defence/self-protection/crisis intervention, testing and drilling on donning and doffing and the respirator protection program), lack of access to appropriate personal protective equipment, supervisor competency and lack of measures and procedures (such as outlined in Section 9 of the “Health Care and Residential Facilities Regulation”) are all examples of indirect causes of injuries. Indirect causes of injuries/illnesses are also referred to as root causes and can be due to human error (e.g., inadequate employer urgency to comply with the OHSA and provide personal panic alarms that can summon immediate assistance to security guards with a GPS/wireless type of locating device when violence occurs), equipment malfunction and environmental or administration factors (lack of process to cohort staff and patients/residents during a pandemic/outbreak, poor ventilation), among other things.

Occupational illness

In addition to investigating fatalities, injuries and accidents, JHSCs and health and safety representatives should also investigate occupational illnesses. It is important to remember that the occupational illnesses that make workers ill, cause disease and kill workers usually result from exposure to toxic substances and/or infectious diseases and are often not identified until many years after initial exposure. In part for this reason, and also because of the difficulty of often linking a disease to exposure to a specific toxic substance for instance, occupational illness investigations require extensive evidence collection (hospital records, autopsy reports, exposure level reports, interviews/witness statements, policies, measures, procedures and type of training provided and in place, ineffective government directives and guidelines, emerging research, etc.) over an extended period of time, or like with COVID-19, during the period when workers were at risk.

What do you do if a fatality, critical injury, illness, accident occurs?

The first people on the scene of a fatality, accident or incident must deal with the immediate incident. As the designated worker members of the JHSC, selected by worker members of the JHSC to investigate, you will want to make note of the following:

- Did the injured person require and receive immediate medical attention?
- Was the fatality, critical injury, illness, accident reported immediately to a supervisor or appropriate person at the workplace? What actions did they take, were the actions suitable in the circumstances?
- If this incident is a fatality or critical injury/illness, was it immediately reported to the JHSC, the trade union and the MLTSD? If not, why not?
- Once the injured person is looked after, was the site secured, was any equipment or machinery used shut down if involved?
- Take a look at the site and make note of anything that may have been removed or moved or tampered with unless it was necessary to attend to injured persons or to prevent further injuries.
- Make sure all witnesses are identified.
- Make note of and take pictures of any blood in the area.
- The MLTSD must be called and the scene preserved and, depending on the incident, the police may also be called to investigate (e.g., workplace violence). Inspectors and police have the right to collect and remove samples and equipment for analysis. If this happens, make note of it in your investigation report. Document what was removed and the location from where it was taken.

The investigation team must be ready to perform its duties. It would be a best practice for JHSC worker members to pre-select which worker members of the JHSC will be designated to conduct the fatality, critical injury or illness investigation should one ever occur (e.g., if an ONA member is critically injured, the committee should pre-select at least an ONA member and possibly other members of the JHSC to conduct the investigation. If it is another union’s member, the committee might pre-select at least one or more members from that union to participate in the worker investigation). The employer does not get to choose or limit how many worker members will conduct the investigation. If a committee is not immediately notified of a fatality or critical injury, the powers of worker committee members may be obstructed and they may be hindered in conducting their immediate investigation.

An investigation kit should also be prepared ahead of time that contains:
- A camera or digital device to photograph evidence
- Tape measure
- Pads of paper and pens
- Investigation checklist
- Flashlight with extra batteries
- Audiotape and/or video recorder
- Clear plastic bags to collect and protect physical evidence
- Personal protective equipment (PPE), including protective gloves, respirators, face shields/goggles, impermeable gowns, head and foot protection, etc.

The JHSC worker members designated to investigate should record all information they gather. Their job is to uncover all sources of information. This means information should be gathered from but not be limited to:
- Injured workers
- Managers
- Eyewitnesses
- Physical evidence
- Background information
- Police
Gathering evidence

It is important that the investigator gathers as much evidence as possible during the investigation. Evidence can consist of testimony of witnesses or physical objects or things such as samples, photos, writings, e-mails, documents, etc., which are used to prove facts. Statements from witnesses, the injured/ill employee and the injured/ill employee’s supervisor at the time of the accident, management who are owners of and/or responsible to implement particular policies, measures or procedures that were relevant in this situation, JHSC members (to determine what knowledge and actions they are aware of for particular relevant hazards and whether they were consulted in the development of these policies, measures, procedures and training). Interviews with all relevant witnesses should be completed as soon as possible after the fatality, critical injury, illness, accident and exposure has occurred when recollections are fresh and most reliable.

The JHSC or health and safety representative can request copies of employer reports, and other resources can also be examined (such as police, paramedic, public health unit and newspaper reports). The investigator may also take photos of the accident scene or draw diagrams, if necessary, being careful not to disturb any evidence. Other sources the investigator may find useful when gathering evidence include:

- Minutes of JHSC meetings;
- JHSC inspection reports, employer health and safety policies, measures, procedures and complaints;
- Incident reports, evidence of worker training, including training content/records (e.g., WHMIS, respiratory protection program training, including fit-testing, donning and doffing, care, use and limitations, crisis intervention training in self-defence/protection, identification of risk (flagging) procedures, training on personal panic alarms, safe-lift device-training, etc.);
- Evidence of Supervisor Awareness training and also Supervisor Competency training, WSIB reports;
- MLTSD reports/orders/visits, emergency procedures;
- Maintenance reports;
- Consultant and expert reports, samples and sample analyses, purchasing records to demonstrate what type of PPE the employer has tried to procure and from what suppliers etc.

Interviewing

When interviewing a witness, begin by introducing yourself and outlining why you are conducting the interview. Personal comfort has a large effect on how an interview or statement-taking proceeds. It is important to obtain the witness’s personal unassisted recollection of events relevant to the investigation. For that reason, it is preferable to interview the witness alone. However, you may wish to consider allowing them to have someone present (friend, relative, union representative) if it will increase their comfort level, providing that the person accompanying the witness does not assist them in responding. Witnesses will be hesitant to speak if they are fearful that they will be blamed for the injury, illness, and accident. Badgering a witness will only make your investigation more difficult.

Try to limit your team of questioners to one or two people. Listen openly to the witness, interrupting as little as possible, and carefully note their statements.
In order to identify the cause of the accident, ONA’s *Investigation Form for Fatality, Critical Injury, Illness, Accident, and Exposure* provides a list of questions to be used as a reference.

**Recording Witness Information**

You have two choices:

1. The ONA *Witness Form for Fatality, Critical Injury, Illness, Accident, and Exposure* can be photocopied and used to record all witness statements. Use as many of the *Witness Forms* as necessary to fully record all details reported by each witness (e.g. injured worker, co-worker, supervisor, expert and any other relevant witness). When choosing this method, use the questions contained in the ONA *Investigation Form for Fatality, Critical Injury, Illness, Accident, and Exposure* to guide your interview/questioning.

2. Record responses to relevant questions directly on the ONA *Investigation Form for Fatality, Critical Injury, Illness, Accident, and Exposure*, using extra space as required.

Record the exact words used by each witness or a synopsis of what they said. When you have finished taking a statement, read it aloud and have the witness attest that it is an accurate account of what they have told you. If there are any errors, you should draw a single line through the error and insert the correction above and have the witness initial the correction. The witness should then sign and date the statement and record the time. Where multiple ONA *Witness Forms* are used, the witness should, after attesting that it is accurate, initial each page and sign and date the last page. Provide the witness with a photocopy of their statement, if requested.

A good investigator gives all relevant witnesses, including experts, an opportunity to speak about the accident. In the case of a critical or fatal investigation (e.g. SARS, Violence), this may mean upwards of 15 (and often many more) people. Such a large investigation will require an investigative team where tasks are split up among multiple investigators. Assigning specific tasks to specific people is a good way to ensure no information or witnesses are left out. Remember, under the *OHSA*, worker members of the JHSC can designate one or more members to investigate cases where a worker was killed or critically injured at a workplace from any cause, but only one of those members can inspect the place where the accident occurred and any machine device or thing, and shall report their findings to a Director (MLTSD) and to the committee.

**Traumatized witness or victim**

Anyone who has seen or been involved in an accident, especially the serious injury/illness or death of a co-worker, will be greatly affected. You may encounter a wide range of reactions, including anger and withdrawal. These reactions are normal and are part of the grieving process.

**Photographs and sketches**

If you are able, take photographs of the accident scene. Try and take pictures from a number of angles and distances, and also include any equipment and hazardous substances that are present and any PPE worn or available. If taking photographs is not an option, make a sketch. You can also take measurements, if necessary.