ONTARIO NURSES' ASSOCIATION

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

A Guide for ONA Members

March 2025

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.

TABLE OF CONTENTS

Introduction **3**
Purpose of an Investigation for Fatality, Critical Injury, Illness, Accident or Exposure **4**
Key Concepts in the Occupational Health and Safety Act **5**
Duty of employer to notify of death or critical injury/illness 5
Duty of employer to notify other injuries/illnesses 6
Right to conduct a fatal or critical injury/illness investigation **7**
Investigation of other injuries and near misses **7**
Employer response to written recommendations **8**
Unresolved Health and Safety issues 8
Conducting an Investigation **9**
Fatality, Critical Injury, Illness, Accident and Exposure causes 9
Direct Causes 9
Indirect Causes 9
Occupational Illness 9
What do you do if a fatality, critical injury, illness, accident occurs? 10
Gathering Evidence 12
Interviewing 13
Recording Witness Information 13
Traumatized Witness or Victim 14
Photographs and Sketches 14
Samples/Reports 14
Note Taking 15
What if you are denied access to an accident scene? 15
What if a workplace party will not cooperate with your investigation? 15
What happens after all the information/evidence/statements are collected? 16
Monitoring and Evaluation 18

APPENDIX A:
Investigation Form for Fatality, Critical Injury, Illness, Accident and Exposure **19**

APPENDIX B:
Witness Form for Fatality, Critical Injury, Illness, Accident and Exposure **38**

INTRODUCTION

The goal of this booklet is to assist ONA members in investigating workplace accidents, fatalities and critical injuries, 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
- Key Concepts in the *Occupational Health and Safety Act (OHSA)*.
- 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. The corrective actions are required under Regulation 420 section 4(2) of the OHSA as "The steps taken to prevent a recurrence or further illness." It is important to note that this regulation covers all ONA workplaces.

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

Critical injury is defined in Regulation 420 section 1(1) as:

"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, or
(g) causes the loss of sight in an eye; ("gravement blessé")

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, Immigration, Training and Skills Development (MLITSD) did confirm that probable SARS cases were critical injuries, even though they were also considered to be occupational illnesses.

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 MLITSD Inspector under Section 8 (14). 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: *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

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.

Samples/Reports

Depending on the type of accident/illness, you may find it useful to retrieve samples or material objects for analysis or reports. In the case of a fatal or critical investigation, it is likely that the MLTSD Inspector or other official investigator will collect these types of evidence, in which case you should request copies of reports

of any analyses conducted. This would include any report prepared by Public Health Ontario (PHO) for the purpose of contact tracing.
Note: Under the *OHSA,* the employer must provide the results of any report respecting occupational health and safety to the entire JHSC, and if that report is in writing (which it usually is) must provide a copy of the portions of the report relevant to occupational health and safety (reference: Section 25 (2) (l) *OHSA*).

Note taking

In addition to recording witness statements on the forms, the investigator should use a notebook to record their investigative activities, starting each entry with the date, time and setting. Notes should include times, dates, places of interviews and other evidence collected, observations of witness demeanor, condition of interview settings, scenes and other information. These personal notes can be used to prepare the final (more comprehensive) report and recommendations. The investigator should take notes of all relevant observations. Taking complete, accurate and orderly notes is essential for recalling information and for ensuring no important evidence is overlooked.

What if you are denied access to an accident scene?

It is your right under the *OHSA* section 9 (31) to investigate accidents to workers resulting in a fatality or critical injury/illness. Try to gather as much evidence as possible. If you face obstacles, call the MLTSD inspector to file a formal complaint and ask for an order that the worker members of the JHSC (or the health and safety representative in workplaces with six to 19 workers) to be allowed to conduct an investigation under Section 9 (31) of the OHSA. Keep in mind that in some instances, another jurisdiction's investigation may affect your role as an investigator.

What if a workplace party will not cooperate with your Investigation?

The JHSC has the power, and it is their function, to investigate any work-related fatality or critical injury, which as noted above includes any critical illness (reference: Section 9 (31) *OHSA*). A JHSC member cannot be obstructed in the performance of any duty or power (reference Section 62 (5) of the *OHSA*). If you face obstacles, call the MLTSD inspector and file a formal complaint asking for an order under Section 62 (5) for obstructing a JHSC member in exercising a power or performance of a duty under Section 9 (31) of the *OHSA*. If the inspector will not write orders, speak to your LRO about the possibility of filing an appeal with the OLRB. We only have

30 days from the date of the Inspector's decision to file an appeal, so notify the LRO immediately as soon as you call the MLTSD.

What happens after all the information/evidence/statements are collected?

After the investigation is complete, it will be necessary for the designated worker members of the JHSC or health and safety representative to write a report of its findings, which includes recommendations. A copy of the report with the recommendations should be provided to the MLTSD and presented and discussed at a JHSC meeting. The report and recommendations should be sent to the employer in writing without delay to respond and address.

While a clear and easy-to-read format is useful, the most important thing is that all aspects of the investigation are covered in the report. A copy of it should also be sent to the union Local and the witnesses who request it. A health and safety representative in workplaces with six to 19 workers has a legal obligation to also forward their findings in writing to the MLTSD Inspector. The health and safety representative should also forward a copy to the employer, the union Local and the witnesses who request it. Any progress or recommendations made by the JHSC or the health and safety representative should also be communicated to the workers involved in the investigation.

The report (which describes what happened and caused the accident) should begin with a cover page and table of contents. Recommendations should also be made in the report and be specific to address all root and contributing causes (direct and indirect) and have timelines included for corrective measures to prevent a recurrence. The report can then be broken down into sections and subsections, which may include but not be limited to any or all of the following:

1. Fatality, Critical Injury, Illness, Accident, or Exposure Event
   a) Time and date of fatality, accident, injury, illness, and exposure.
   b) Person(s) involved in fatality, accident, injury, illness, and exposure (victim, witnesses).
   c) Activity being performed at time of fatality, accident, injury, illness, and exposure.
   d) Type and seriousness of injury/illness.
   e) Patients, equipment, materials, processes, environmental, system factors (external and internal) and supplies involved (or lack of).
   f) Personal factors.

(Photographs and sketches, witness forms and interview responses can be included at the end of this section, or attached as an appendix.)

2. Injured Worker and Eye-Witnesses Account
3. Physical Evidence
4. Photographs and drawings
5. Background Information (to include, if any):

   a) Controls and training.
   b) Health and safety measures/procedures/policies/programs.
   c) Legal requirements.
   d) Employee complaints.
   e) Prior similar incidents/exposures.
   f) Prior JHSC Inspections/minutes
   g) Organizational Risk Assessment (e.g., violence or infectious disease threat assessments).
   h) Expert reports.
   i) Ministry orders.

(Reports, orders, policy, measures, procedure documents, etc. can be included at the end of this section, or attached as an appendix.)

3. Findings
   a) Direct causes (hazardous substances, sharps, infectious disease, patient/resident action (e.g., violence).
   b) Indirect causes (non-existent or unsafe policies, measures, procedures, training etc. that created an unsafe work environment, unsafe conditions or acts etc. as noted on page 6).

4. Recommendations
   a) Changes recommended (in order of priority and numbered).
   b) Timetable for implementing changes.

Any conclusions or findings made in the report need to be supported by evidence. Evidence includes worker statements, proof of a gap in a policy, measures, procedures, training, external factors (e.g., no Memorandum of Agreement with the police to share information about a patient's history of violent behaviour with the employer/workers), JHSC minutes/inspection reports or recommendations that were not addressed properly, etc.

Recommendations should be developed out of these conclusions and findings and a copy of the report with the recommendations should be provided to the MLTSD and presented and discussed at a JHSC meeting. The *OHSA* does not require the JHSC to approve the report but it is a good practice to do so. The report and recommendations should be sent to the employer in writing without delay to respond and address. While a clear and easy-to-read format is useful, the most important thing is that all aspects of the investigation are covered in the report. A copy of it should also be sent to the union Local and the witnesses who request it. A health and safety representative in workplaces with six to 19 workers has a legal obligation to also forward their findings in writing to the MLTSD Inspector. The health and safety representative should also forward a copy to the employer, the union Local and the witnesses who request it.

Monitoring and Evaluation

The JHSC and employer should monitor and evaluate the changes to ensure the desired outcome to prevent a recurrence was achieved.

APPENDIX A:

Investigation Form for Fatality, Critical Injury, Illness, Accident, and Exposure

Please consult the ONA Investigation Guide to Fatality, Critical Injury, Illness, Accident, and Exposure for information on how to complete this form and/or the ONA Witness Form, for Fatality, Critical Injury, Illness, Accident, and Exposure, including a definition of workplace fatality and/or critical injury/illness. These forms can be found on the ONA website in the health and safety section at:

https://ona.org/wp-content/uploads/2024/10/hs_investigationformfatalitycriticalnjuryillnessaccidentalexposure_20241028.docx

Recording Witness Information

You have two choices:

1. The ONA *Witness Form* 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 this form to guide your interview/questioning.
2. Record responses to relevant questions directly on this form, using extra space as required.

Name of Injured:			
Phone Number:			
Address:			
Age:		Gender:	
Occupation:		Seniority:	
Employment Status:	FT ( ) PT ( ) CA ( )		
Unit/Department:			
Supervisor:			
Date of Fatality, Critical Injury, Illness, Accident, and Exposure:		Time:	
Name of Employer:			

Date and time the following parties were notified:

Ministry of Labour, Training and Skills	
Development (MLTSD)	
Joint Health and Safety Committee (JHSC)	
Trade Union	

Health and Safety Representative (in workplace with six to 19 workers)

Exact Workplace Location of Fatality, Critical Injury, Illness, Accident, and Exposure

Nature of Fatality or Severity and Nature of Injury/Illness

Please elaborate on the nature of the fatality/injury/illness (part of body involved/injured/ ill/exposed, diagnosis if available):

Photos

If possible, take a number of pictures of the scene where the accident/exposure occurred, ensuring the date is captured on the photo. Being careful not to disturb the evidence, take both close-ups of the accident/exposure scene and a picture of where the accident/exposure scene is in relation to the rest of the workplace. Capture where all equipment is located, or in the case of infectious diseases such as SARS or COVID-19, noting where all patients are/were located, (e.g. identifying those with COVID-19 and those who did not have COVID-19) and the exact position where the accident/exposure occurred. Take pictures of the common areas as well (e.g. nursing stations, dining room, shared washrooms, lunchrooms for staff, personal protective equipment (PPE) supply rooms, etc.). In the case of workplace violence, take a photo of the room where the violence occurred and note any machine, device or thing used in the assault (e.g. knife).

Background Information

JHSC worker designated investigators also need to examine relevant background information. This can include but not be limited to information such as past JHSC minutes, accident/incident/exposure/hazard reports, workplace inspection reports, training materials/ records, policies, measures and procedures (system-wide and unit-specific) and maintenance records. This information might show unsafe conditions, gaps in measures, procedures and training, previous fatalities, critical injury, illnesses, accidents, and exposures or near misses. These records can give JHSC worker designated investigators information to help identify causes and act to prevent further fatalities, critical injury, illnesses, accidents, and exposures. The designated JHSC worker investigators should be able to identify what caused the fatality, critical injury, illness, accident, and exposure by combining all of the information from the background information and all of the different sources, including witness statements.

Questioning Witnesses/Taking Statements

The investigator should begin by allowing the injured worker, witnesses and supervisor to give an account of the accident/exposure in their own words. Listen openly to the witness, with minimal interruptions. After listening to the witness's brief account of what occurred, explain that you will now ask a number of questions and document the responses in order to better understand the events of the fatality, injury, illness, accident, and exposure.

The attached questions may be used or adapted to assist you in questioning witnesses. This is only a *suggested* tool, which may be useful. Remember, your goal is to obtain, in as much detail as possible, the witness's personal account of information relevant to the investigation. As such, you may develop questions not included in this investigation form.

Document the witness's responses directly beneath the questions, or on the ONA *Witness Form*, ensuring that you record the name of the witness and the interviewer and the date/time/location of the interview.

Record the exact words used by each witness or a synopsis of what they have 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 also 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.

After the Fatality, Critical Injury, Illness, Accident, and Exposure Investigation is Complete

After the investigation is complete, it will be necessary for the designated worker members of the JHSC or health in safety representative (in workplaces with six to 19 workers) to write a report of its findings, which includes recommendations. A copy of the report with the recommendations should be provided to the MLTSD and presented and discussed at a JHSC meeting. The report and recommendations should be sent to the employer in writing without delay to respond and address.

In smaller organizations where there is no JHSC, the health and safety representative/investigator should make written recommendations based on the information collected in this form to the employer.

Suggested Interview Questions for Witnesses (e.g. injured worker, supervisor, co-worker, expert)

Below is a series of questions, divided by section, to guide your interview. Use only the sections that are applicable. Either document the witness's responses directly beneath the questions or on the ONA *Witness Form*, ensuring that you record the name of the witness and the interviewer and the date/time/location of the interview. After the interview is complete, both the interviewer and the witness should sign and date the document, and also record the time of the interview. If using the ONA *Witness Form,* the witness should initial each form and sign, date and record the time on the last form.

Name of Witness:	
Position of Witness:	
Witness's Supervisor:	
Date/Time/Location of Interview:	
Name of Interviewer:	

Sample Investigation Questions

Below are a list of sample investigation questions organized into the following sections for easy reference:

Fatality, Critical Injury, Illness, Accident, and Exposure Event Infectious

Disease – Occupational Illnesses

Equipment and Protective Devices Sharps

Hazardous Substances

Environmental Factors

Personal Factors Workplace

Violence Employee

Complaints Management

Awareness

Joint Health and Safety Committee (JHSC)

Review any relevant sections related to your investigation to support your investigation. Remember to prompt the witness for more details where needed.

Fatality, Critical Injury, Illness, Accident, and Exposure Event

1. Please name all people that you are aware of who witnessed and/or were exposed to the fatality, critical injury, illness, accident, and exposure. Where exactly were they in relation to the victim/you?

2. Describe how and what you were doing when the fatality, critical injury, illness, accident, and exposure happened. Where exactly were you in relation to the victim?

3. What were you/the worker doing just before the incident occurred?

4. Describe the activity, as well as the **people** (includes patients and any staff and actions taken or not taken), **equipment** (state and maintenance of equipment, proper or improper for task), **materials** (proper or improper for task), **environment** (state and condition of environment), **processes** (proper or improper for task; gaps in procedures, followed, followed improperly, not followed), **supplies** (involved, provided or not provided, appropriate for the task, access to, etc.), **system** (internal and external factors). Be specific.

5. Please describe the work area.

6. What (in exhaustive detail) happened (for example, when re-capping sharp, worker obtained a needlestick injury to her left hand or worker was assigned and took care of COVID-19 patients for three shifts and started feeling ill at work on day 3)? Please assume I know absolutely nothing about the task(s) or job you performed and walk me through it, step by step.

7. What was the injury, illness, accident, and exposure?

8. What object or substance directly harmed you/the worker (for example, concrete floor, sharp, ceiling lift, infectious disease, exposure to SARS, COVID-19, a knife)?

Infectious Disease – Occupational Illnesses

1. In the case of infectious disease, which colleagues were you or the affected worker exposed to and which colleagues cared for infected patients/residents?

2. When did you/the worker/colleagues provide care to the infected patients/residents, for what length of time, and what type of care did you provide?

3. Please describe any opportunity for you/the worker to have been exposed to an infectious patient/resident, regardless of the type of personal protective equipment (PPE) you may or may not have been wearing.

4. What substance(s) or infectious disease have you/the worker been exposed to?

5. What level of exposure to the toxic substances or infectious disease have you/the worker had?

6. Are you aware of your employer's pandemic/emergency plan in place for an outbreak, emergency or pandemic? If so, please explain what processes you are aware of.

7. Is there an outbreak in your facility (e.g. patients, residents or any staff)?

8. Were infectious patients/residents isolated in a negative pressure room? Please describe.

9. Were infectious patients/residents cohorted with others with like illness, and were staff cohorted? Please describe.

10. Was air quality measured and, if so, by whom? (Attach a copy of the report.)

11. Was the location of the exposure disturbed or different prior to the measurement?

12. In the case of a fatality, what was the exact cause of death? Were other diseases present? (If the worker died of cancer, has the latency requirement been met?)

13. Are people who worked in the same area still alive? Are they well? If they are sick, what disease do they have? If some have died, what was their cause of death?

Equipment and Protective Devices

1. Did you/the injured/ill worker wear personal protective equipment (PPE)? What kind of PPE was worn (list all, e.g. personal panic alarms, spit guard, Kevlar gloves, surgical mask and/or N95 or better respirator, face shield, goggles, head and foot protection, impermeable gown, gloves, etc.)? How often during a shift would it be worn and were there any moments when it was not worn and where? Describe in detail.

2. Are you aware of whether you/the worker were required by the employer or the *Occupational Health and Safety Act (OSHA)* to wear or use any protective clothing, equipment or device?

3. Were the equipment, materials and protective devices needed provided by the employer? What were they?

4. Did you/the worker/colleagues perform a fit/seal check prior to putting on the equipment?

5. Was the equipment a proper fit? If not, please describe.

6. Were the equipment, materials and protective devices provided by the employer maintained and in good condition? How often was the equipment inspected for damage and deterioration? By whom? Was the equipment stored in a convenient, clean and sanitary location when not in use?

7. Did the employer have a respiratory protection program? If so, please provide a copy.

8. Were you/the worker(s) trained and educated in the respiratory protection program and care, use and limitations of any protective clothing, equipment or device before wearing or using it for the first time and at regular intervals thereafter? Please describe the type and length of any training in detail (e.g. video, in-person, eLearning, email, posters, etc.).

9. What other related training have you/the employee received?

10. Was there enough equipment, protective clothing and devices? Please describe.

11. Was there equipment failure? Please describe.

12. Did the location or accessibility of the equipment create or contribute to the hazard? If so, please describe.

13. Were the equipment, materials and protective devices provided by the employer used as prescribed under the Health Care and Residential Facilities Regulation or Industrial Establishment Regulation or Control of Exposure to Biological or Chemical Agents Regulation of the *OHSA?* Were other related prescribed measures and procedures carried out in the workplace?

Sharps

1. If a sharp was involved, please state the part of the handling process that led to the injury: re-capping, veno puncture/arterio puncture, sharps disposal, etc. Please be as specific as possible.

2. Describe the type of needle devices used at the time of the accident (e.g. conventional or safety-engineered and brand).

3. Where was the sharps container located in conjunction with the location of the injury/accident?

Hazardous Substances

1. Were hazardous substances involved? If so, please describe.

2. Were they clearly labeled? Please describe.

3. How many workers were exposed to the hazard?

4. How many workers routinely come in contact with the hazard?

5. Were Safety Data Sheets (SDS) accessible to you/the worker?

6. Has an assessment for the hazard been done or previously been done? Please explain.

7. Is there a health and safety program designed to control the hazard(s) that resulted in this accident?

8. Are controls, training and education for workers about hazardous substances currently in place? Please describe.

9. Does your supervisor/employer regularly advise you of new hazards? If so, how?

10. When were you/the injured worker last trained, by whom, where, for how long and what type of training was it (e.g. video, eLearning, communication or in-person, etc.)?

Environmental Factors

1. Did any of the following environmental factors play a role in the accident: noise, lighting, ventilation, workspace, patient/resident or public aggression? Please describe.

2. How effective is the ventilation system at work? How many air changes per hour (e.g. in the patient rooms, common areas, etc.)? When was the last time the ventilation system was checked (e.g. six months, one year)?

Personal Factors

1. How experienced were you/the employee in the task or work area? How long have you worked at the task and in the work area?

2. Was worker stress a factor in the fatality, injury, illness, and accident? If so, please describe.

3. Was the work too physically demanding for you/the worker? If so, please describe.

4. When, in relation to your/the injured worker's shift/hours at work, did the fatality, injury, illness, and accident occur? (For example, 30 minutes before the shift change, or during the second hour of overtime, or after a day and night shift with no time off in between?)

5. What workload or hours of work did you/the worker perform? Had it increased? Was overtime involved?

6. What were the staffing levels like on the shifts where you/the worker may have been exposed?

Workplace Violence

1. Describe your/the worker's relationship with the patient/resident.

2. What did you see at the time of the incident?

3. Describe the scene.

4. What did you hear?

5. Who else was in the area at the time of the incidents?

6. Was a code white called? If yes, please explain who came to the code white? If not, why not?

7. Describe what actions you observed others taking before, during and after the incident?

8. When did the violent person enter the facility and by what means? Were any concerns raised at that time?

9. Was the violent person admitted and were any concerns about that person raised at that time? If so, to whom?

10. What knowledge did you/the worker, other workers, employer, police, etc. have about the violent person's history of violent behaviour? How do you know this?

11. How are you usually made aware of a person's history of violent behaviour?

12. What means of summoning immediate assistance when the violence occurred did the worker(s) have? Please describe in detail.

13. Tell me about any concerns/incidents that took place leading up to the complaint/assault.

14. Have there been any previous concerns raised by workers about the risk of workplace violence? Please describe in detail.

15. Please describe the staffing levels/skills mix at the time of the incident and in the shifts prior to the incident.

16. What is the role of security guards in relation to workplace violence and what role, if any, did they play in relation to this incident?

17. Are you aware of any other factors that may have contributed to the unsafe working conditions?

Employee Complaints

1. Are there any employee complaints connected with the cause of the fatality, injury, illness, accident, and exposure? What are the complaints and are they associated with a specific time or area or previous shift?

Management Awareness

1. Were any supervisors present when the fatality, injury, illness, accident, and exposure occurred? If so, please share their name and title.

2. When and where were the supervisors when the fatality, injury, illness, accident, and exposure occurred? What did they do in response to the fatality, injury, illness, accident, and exposure?

3. Were any supervisors aware beforehand of the problem that led to the fatality, injury, illness, and accident? Please describe in detail.

4. How do you know that the supervisors were aware of the problem?

5. Do supervisors normally advise you/the worker/colleagues about hazards in the workplace?

Joint Health and Safety Committee (JHSC)

1. Are you/the worker aware of the activities of the JHSC? Please list some of the committee's recent activities.

2. Please name the JHSC worker co-chair or a JHSC representative in the hospital/facility.

3. Does the employer, on the advice of the JHSC or health and safety representative (in workplaces with six to 19 workers), review and revise the measures and procedures for the health and safety of workers at least once a year? When was the last time the policies, measures, procedures listed in question 1 below, under the heading "Policy," were reviewed and revised?

4. Is the JHSC or health and safety representative regularly consulted on the development of any new health and safety policies, measures, procedures and programs (violence prevention, infection control, etc.)?

5. Is the JHSC or health and safety representative regularly consulted when developing, establishing and providing training and educational programs for the measures and procedures that are relevant to the worker's work and this incident?

6. As a JHSC member or health and safety representative, have you ever raised concerns to the employer of issues related to this incident? How were they addressed?

Indirect Cause

The causes of injuries are not always direct. The questions in this form have been designed to help elicit information on the root cause of the injury (for example, while a nurse's exposure to SARS or COVID-19 patients/residents may have been the direct cause of their critical injury/illness, a lack of personal protective equipment, or ill-fitting equipment, or inappropriate health and safety procedures may have indirectly led to the fatality, injury, illness, and exposure).

1. Do you have any further comments on the cause of the fatality, injury, illness, and exposure under investigation?

Policy

A lack of adequate health and safety policies may also be considered an indirect cause of a fatality, injury, illness, accident, and exposure.

1. Which of the following health and safety measures and procedures does the employer have in place (as laid out in Section 9(1) of Regulation 67/93, Health Care and Residential Facilities of the *OHSA*)?

In Place	Measures/Procedures/Policy/Program
	(Please specify where you know if the item listed below is in the form of a measure/procedure/policy/program or all).
Yes ( ) No ( )	Safe work practices (please describe all).

Yes ( ) No ( )	Safe working conditions (please describe all).
Yes ( ) No ( )	Proper hygiene practices and the use of hygiene facilities (please describe).
Yes ( ) No ( )	The control of infections (please describe in detail).
Yes ( ) No ( )	Immunization and inoculation against infectious diseases.
Yes ( ) No ( )	The use of appropriate antiseptics, disinfectants and decontaminants.
Yes ( ) No ( )	The hazards of biological, chemical and physical agents present in the workplace, including the hazards of dispensing or administering such agents (please describe).
Yes ( ) No ( )	Measures to protect workers from exposure to a biological, chemical or physical agent that is or may be a hazard to the reproductive capacity of a worker, the pregnancy of a worker or the nursing of a child of a worker.
Yes ( ) No ( )	The proper use, maintenance and operation of equipment (please describe in detail).
Yes ( ) No ( )	The reporting of unsafe or defective devices, equipment or work surfaces (please describe).
Yes ( ) No ( )	The purchasing of equipment that is properly designed and constructed (please describe).
Yes ( ) No ( )	The use, wearing and care of personal protective equipment and its limitations (please describe).

Yes ( ) No ( )	The handling, cleaning and disposal of soiled linen, sharp objects and waste (please describe).

1. Is there any training/education/instruction in health and safety policy, procedures and protective measures that is directly related to the fatality, injury, illness, and accident? How do you know about this training/education/instruction?

2. Did you feel competent to put into practice the skills learned after the training and education that you received in health and safety policy, procedures and protective measures? Please describe.

Knowledge of Prior Similar Incidents

1. Are you aware of any prior similar incidents? Please describe.

2. Are you aware if any prior similar incidents have been reported? Please describe.

3. When and to whom were the prior similar incidents reported? What was done in response?

4. Are you aware of any workload complaints that may have been filed that may be relevant to this fatality, critical injury, illness, accident, and exposure?

Expert Reports

1. Are you aware of any consultants that have come in and conducted tests or studied this fatality, critical injury, illness, accident, and exposure or any related issues?

2. Are you aware of any reports of this fatality, critical injury, illness, accident, and exposure or any related issues? Can I have a copy?

3. Are you aware of any other Ministry or other body that has also conducted some form of investigation or study into any related fatality, critical injury, illness, accident, and exposure or related issues now or in the past (e.g. Public Health, the police, the Centers for Disease Control, etc.)?

4. Are you aware of any MLTSD orders that have been issued in the past for similar infractions/hazards?

Recommendations

1. Have any changes been made as a result of the fatality, critical injury, illness, accident, and exposure?

2. What changes are planned as a result of the fatality, critical injury, illness, accident, and exposure?

3. What do you think should happen to correct the problem(s)?

Signature of Witness:		Date:	
Signature of Interviewer:		Date:	

APPENDIX B:

Witness Form for Fatality, Critical Injury, Illness, Accident, and Exposure

Please photocopy this form and use as many of the *Witness Forms* as necessary to fully record all details of each witness's (e.g. injured worker, co-worker, supervisor, expert and any other relevant witness) responses as reported during the interview. 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. These forms can be found on the ONA website in the health and safety section at https://ona.org/wp-content/uploads/2024/10/hs_witnessformfatalitycriticalnjuryillnessaccidentalexposure_20241028.docx

Time of Interview:		Date of Interview:	
Place of Interview:			
Name of Witness:			
Address of Witness:			
Phone Number of Witness:			
Email of Witness:			
Name of Interviewer:			

Witness Statement:

Is this an accurate account of what you just told me?

Witness Signature:		Date:	
Interviewer Signature:		Date:	