



# Labour

## **A Guide to the Investigation and Reporting of Hazardous Occurrences**

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**A Guide to the  
Investigation and  
Reporting of  
Hazardous Occurrences**

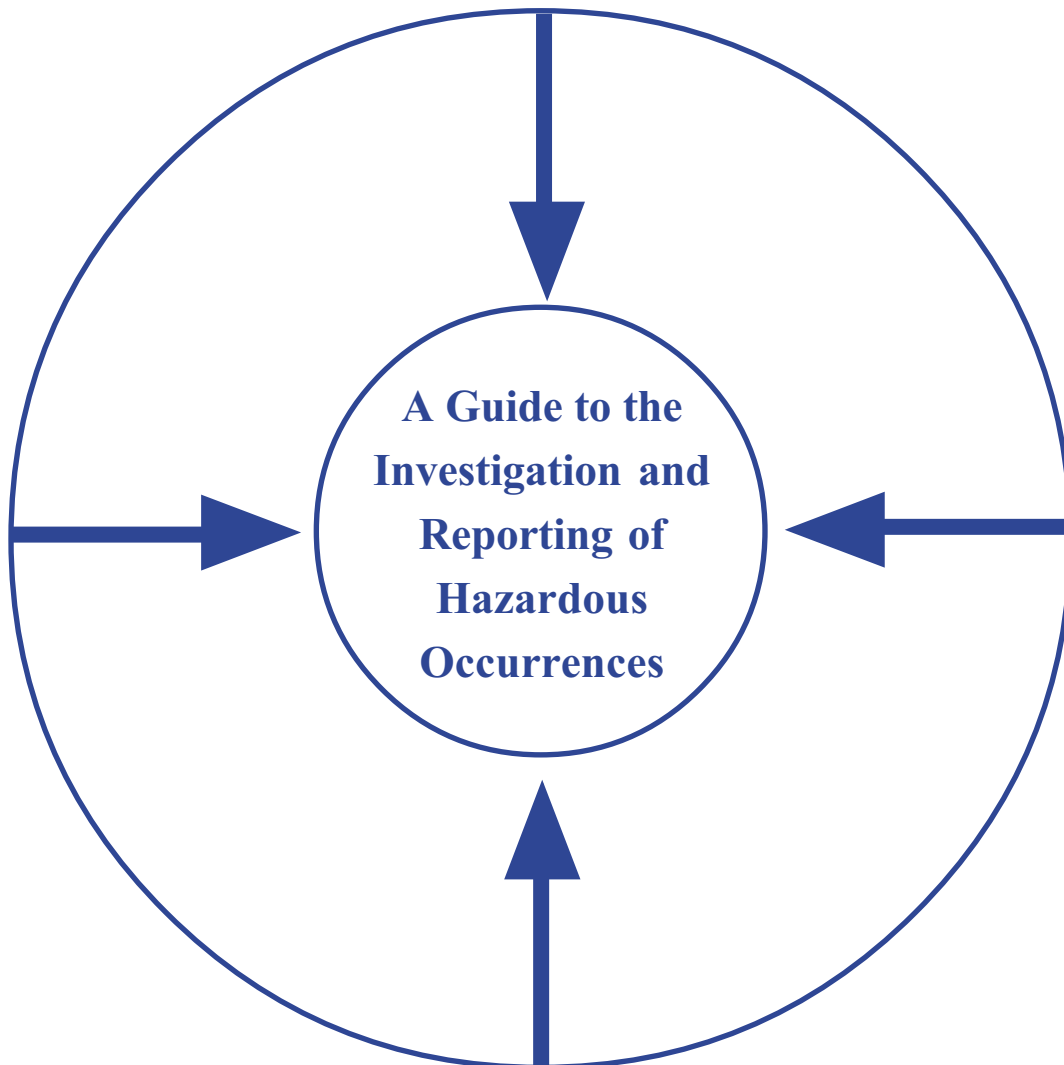


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This booklet is meant as a guide to the investigation and reporting of occupational hazardous occurrences with particular reference to enterprises subject to Part II of the *Canada Labour Code* and the *Canada Occupational Health and Safety Regulations*.

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# Foreword

Hazardous occurrence investigation and reporting are a vital part of every work place health and safety program. In conducting an effective investigation, attention is paid to the roles and responsibilities of everyone involved. The methods of notification, investigation, analysis and reporting of major and minor hazardous occurrences must lead to corrective actions that prevent or reduce the number of hazardous occurrences.

This publication examines these topics to help those who share responsibility for the investigation of hazardous occurrences.



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*The investigation and analysis of all hazardous occurrences are an effective way of preventing accidents in the work place. The investigation and analysis should produce information that leads to corrective actions that prevent or reduce the number of hazardous occurrences.*

*An effective health and safety program prevents and eventually eliminates hazardous occurrences and encourages employees to bring potential hazards in the work place to the attention of supervisors. Hazards thus discovered and reported can be corrected or reduced immediately. If immediate correction is impossible, exposed workers can at least be protected.*

## **Notification of a Hazardous Occurrence**

Part XV of the *Canada Occupational Health and Safety Regulations* requires that employees report to the employer every accident or hazardous occurrence in the course of work that has or is likely to cause an injury. It also requires that every accident, occupational disease and other hazardous occurrence be investigated without delay.

As soon as possible after learning of the occurrence, *the employer must:*

- act to ensure that the occurrence does not happen again;
- appoint a qualified person to carry out an investigation;
- notify the work place committee or representative of the occurrence and of the name of the investigator.

If the hazardous occurrence was a motor vehicle accident on a public road, the employer will investigate by obtaining all police reports where the police investigated the matter. If there is no police report, the employer must investigate.

In all cases, a copy of the investigation report must be given to the work place committee or the health and safety representative.

Employers under federal jurisdiction must report to a health and safety officer of Human Resources and Social Development Canada (Labour Program) as soon as possible but no later than 24 hours after learning that a hazardous occurrence has resulted in:

- (a) the death of an employee;
- (b) a disabling injury to two or more employees;
- (c) the loss by an employee of a body member or part thereof or in the complete loss of the usefulness of the body member;

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- (d) the permanent impairment of a body function of an employee;
  - (e) an explosion;
  - (f) damage to a boiler or pressure vessel that results in fire or the rupture of the boiler or pressure vessel; or
  - (g) any damage to an elevating device that renders it unserviceable, or a free fall of an elevating device.

The Department must conduct an investigation into the circumstances that led to the hazardous occurrence.

For (f) and (g) above, the employer must also make a written record describing the occurrence within 72 hours. It must include the date, time, location, and causes of the occurrence and any action taken to prevent another such occurrence.

## **Investigative Team**

A common weakness of hazardous occurrence investigation and reporting systems is the failure to establish responsibility for this important work. Too often managers regard this as a routine chore of filling in a workers' compensation claim. They assign this to a junior clerk in the personnel section or, if they assign it to a supervisor, it is often seen as a nuisance rather than an important part of the job.

All hazardous occurrences should be investigated without delay by a qualified person available within the organization. This is normally the supervisor of the person involved in the hazardous occurrence. The supervisor is the person who assigned the task and who should know about all aspects of the situation.

The employer must notify the work place committee of the hazardous occurrence. The committee in turn will make sure that it participates in the investigation.

Since hazardous occurrences vary in severity, some changes to the basic investigative team may be necessary. If the hazardous occurrence caused a fatality, a permanent disability or some equally serious results, it would be wise to have a superintendent or senior supervisor direct the investigative team. But in most cases, try not to change the regular organization pattern and avoid the tendency to assign the entire responsibility to the health and safety coordinator.

## **Hazardous Occurrence Investigation**

Despite what many people believe, hazardous occurrence investigation is a fact finding, not a fault finding, process. When trying to determine the cause of an accident, the inexperienced investigator

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may overlook some facts and conclude that the person involved in the accident was at fault. A thorough investigation conducted by an experienced and qualified investigator may reveal that, while employee inattention may have contributed, the actual causes of the hazardous occurrence were either unsafe conditions, unsafe acts, or both. The origin of the causes is often traced back to inadequate management control or inadequate planning.

Another essential ingredient of proper investigation is the recognition of the difference between injury causes and accident causes; the two are rarely the same. The concern of many investigators with injury directs them to determine injury causes only. Corrective measures based only on such causes are unlikely to prevent future hazardous occurrences.

Take for example the following scenario: Harry is asked to work through his lunch hour. He is to split up a few four-by-fours to provide some framing for the work crew after lunch — just a small quick job. He rushes to the saw without his protective glasses and safety helmet. Since the saw guard's splitter bar will not pass through the kerf of the four-by-fours, he removes the guard to get the job done. The company uses recycled wood, and there is a nail left in one of the four-by-fours. The carbide tip blade hits the nail, and broken bits of the blade fly into Harry's eye.

In this example, the accident cause and the injury cause are not the same. The investigator is warned to search out all the unsafe acts and conditions before analyzing the hazardous occurrence and making changes to eliminate the hazards.

Harry was injured by the metal tip of the broken blade flying into his eye. This injury could have been prevented if Harry had worn his protective glasses or used the saw guard. However, the revolving blade would still have hit the imbedded nail. The accident, though not the injury, would still have occurred.

An effective hazardous occurrence investigation will point out that the wood being sawed must be thoroughly inspected. Therefore, the wood will be free of metal, and the saw blades will not strike against any metal. This suggestion will lead to changes in work practice which will prevent similar hazardous occurrences in the future. (See the sample Hazardous Occurrence Investigation Report on page 19 for more details.)

## **Hazardous Occurrence Analysis**

There is usually more than one cause for a hazardous occurrence. A competent investigator notes all causes and follows the trail to a conclusion. After precise analysis, he or she will be able to suggest corrective action for each of these causes.

An inexperienced investigator may stop short of the end of the investigative trail and apply a "quick fix" which may work for a time. The root cause, however, is still left to endanger the workers, and eventually this could cause another hazardous occurrence.

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There is an analysis of the sample hazardous occurrence on page 11. Note that the investigator does not simply say, "Oh, he wasn't wearing protective glasses," or "This wouldn't have happened if he had been wearing his glasses." By continuing to ask, "And what caused this?" the investigator eventually comes to the root of the problem — the nail in the wood. Only then can the investigator make recommendations for follow up action to improve the overall health and safety of the work place.

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# Accident Analysis

**Loss:** Right eye — **Why?**

**Contact:** Saw blade fragments thrown into eye — **Why?**

**Immediate Cause:** Revolving saw blade struck against nail in wood being cut — **Why?**

**Contributing Factors:** See below

## Unsafe Conditions

1. Saw blade struck nail — **why?**
2. Using unchecked recycled wood — **why?**
3. Supplier responsible for checking wood. This lot shipped late on Friday.

### What to do?

Immediately stop using recycled wood until a reliable checking system is in place.

### Who? When?

User of wood is best inspector — check prior to sawing.

### How?

Purchase metal detector and implement inspecting system.

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**Action by:**  
*John Henderson by  
May 2007*

1. Rush job — **why?**
2. Stock of framing used up — **why?**
3. Stock levels do not reflect usage.

### What to do?

Set stock levels based on planned usage. Set restocking levels that will alert shop person to restock supply. This will help prevent “panic” jobs.

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**Action by:**  
*John Henderson by  
September 12, 2007*

1. 4" x 4" jam on table saw — **why?**
2. Guard mounting splitter bar prevents ripping any stock larger than 3 inches thick.

Modification was requested months ago and approved by Engineering Department. Maintenance unable to make change in 3 months because operating with only half staff. They can do only normal routine maintenance.

### What to do?

Work orders relating to safety must be given priority. A safety priority system should be devised and put into operation.

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**Action by:**  
*Bud Palmer by  
September 18, 2007*

**Info:**  
Health and Safety Coordinator  
Work Place Committee

1. Safety inspections did not reveal that tradespeople were removing the guard on the table saw when ripping stock larger than 3 inches.

2. Inspectors and tradespeople took it as a normal condition, as the saw was not designed to cut more than 3 inches in depth.

Better preparation for inspections is required. Review outstanding work orders; expedite if possible. Review job safety analysis for this operation. How was the carpenter supposed to rip 4" x 4"? Suggest discussion with Health and Safety Coordinator and the Work Place Committee.

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**Action by:**  
*Health and Safety Coordinator  
September 18, 2007*

**Info:**  
Work Place Committee

# Unsafe Acts

<ol style="list-style-type: none"> <li>1. Removing saw guard — <b>why?</b></li> <li>2. To get the job done — <b>why?</b></li> <li>3. Small rush job — normal safe work practices were neglected to hasten job.</li> </ol> <p><b>What to do?</b> Have saw modified immediately to ensure no one removes guard to cut 4" x 4"s.</p> <p><b>Note:</b> Work done on saw, September 11, 2007. Saw is safe and running well.</p> <p><i>John Henderson</i></p>	<ol style="list-style-type: none"> <li>1. Not wearing protective glasses — <b>why?</b></li> <li>2. Caught on the way to lunch without his personal protective equipment (PPE). Small rush job — he went directly to work. Safe work practices were neglected.</li> </ol> <p><b>What to do?</b></p>	<ol style="list-style-type: none"> <li>1. User did not check wood he was sawing in normal way — <b>why?</b></li> <li>2. User was hurrying to complete job. He had cut seven pieces already without a problem.</li> </ol> <p><b>What to do?</b></p>
<p>Shop talk with all members of the shop to discuss safe work practices (guards and PPE). Go over company policy and normal work practices. The standard is set and will be used at all times — no exceptions — particularly on "rush" jobs, which tend to be more dangerous because of stress. Supervisors will insist on the standards being maintained.</p> <p><b>Action by:</b> <i>John Henderson by September 12, 2007</i></p>		

<p><b>ACTION:</b></p> <ol style="list-style-type: none"> <li>1. Stop using recycled wood.</li> <li>2. Modify saw or buy appropriate saw.</li> <li>3. Shop talk to tradespeople and then to supervisors.</li> <li>4. Set stock levels for lumber on hand.</li> <li>5. Establish safety priority system for work orders.</li> <li>6. Improve training for safety inspectors.</li> </ol>	<p><b>DATE:</b></p> <p>Done</p> <p>Immediately</p> <p>September 12, 2007</p> <p>September 18, 2007</p>
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## Hazardous Occurrence Report

After a thorough investigation, after the investigator has "zeroed in" on the causes of the hazardous occurrence and is ready to recommend solutions to the problems, the last step is the preparation of a clear, concise report. The report should include the important facts pointing to the causes of the hazardous occurrence and the investigator's recommendations. A well designed hazardous occurrence report form does not guarantee a good report, nor does a badly designed one prevent a good report. Whatever form is used, it is only a vehicle used to communicate information. However, a form can influence the report by highlighting the important features. These are the causes of the hazardous occurrence and the remedial measures recommended to prevent a recurrence. A hazardous occurrence report that does not contain this information is of little use in preventing further hazardous occurrences.

Avoid the temptation to use a compensation claim form as a hazardous occurrence report. Such a form is usually oriented to the injury and directs attention to injury causes rather than to hazardous occurrence causes. The supervisor responsible for the area where the hazardous occurrence took place should complete the hazardous occurrence investigation report. This report is to be used solely as an instrument for preventing hazardous occurrences. The routing, processing, and other details of a hazardous occurrence investigation report may be quite different from those of a compensation claim.

The *Canada Labour Code* requires that all enterprises subject to the *Canada Occupational Health and Safety Regulations* use the standard Hazardous Occurrence Investigation Report form. The use of this form will help in the compilation of nationwide statistics. These forms are available from your local Human Resources and Social Development Canada (Labour Program) office.

Please note, the responsibility of the employer does not end with the completion of the Hazardous Occurrence Investigation Report form. The employer still has to complete the required compensation reports, whether the enterprise falls under provincial or federal legislation.

The following lists of unsafe conditions and unsafe acts will help the accident investigator identify all hazardous occurrence causes and complete the report. Keep in mind that these lists are not all inclusive. On page 19, you will find a sample of a Human Resources and Social Development Canada Hazardous Occurrence Investigation Report form.

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## Unsafe Conditions

### Defects of Equipment

Worn, cracked, broken, etc.  
Slippery  
Improperly designed  
Improperly constructed

### Dress or Apparel Hazards

Lack of necessary personal  
protective equipment  
Improper or inadequate clothing

### Hazards of Outside Work Environment

Hazards of property or operations of  
other employers  
Natural hazards

### Environmental Hazards

Excessive noise  
Inadequate aisles or work space  
Inadequate ventilation  
Inadequate illumination

### Public Hazards

Public transportation hazards  
Traffic hazards

### Hazardous Methods or Procedures

Use of inherently hazardous material  
or equipment  
Use of inherently hazardous procedures  
Use of improper tools or equipment  
Inadequate help for heavy lifting  
Improper assignment of personnel

### Inadequately Guarded Equipment or Materials

Unguarded (mechanical or physical hazards)  
Inadequately guarded  
Ungrounded (electrical)  
Uncovered connections, etc. (electrical)

Unlabelled or inadequately labelled materials  
(WHMIS)

### Other Hazardous Conditions

Hazardous conditions (specify)  
Undetermined —insufficient information

## Personal Factors

Lack of job knowledge  
Lack of job skill  
Failure to follow instructions  
Instructions misunderstood  
Disregard of instructions  
Physical disability  
Other (specify)  
No personal factor involved

## Organizational Causes

Safe job procedures not established  
Safe procedures not understood  
Lack of supervision  
Lack of job training  
Lack of safety instruction on job assignment  
Inadequate safety inspection program  
Lack of follow-up for hazard correction  
Lack of maintenance  
Lack of maintenance staff  
Awaiting delivery of material or supplies  
for correction  
Lack of safety standards in design  
and construction  
Lack of safety specifications for purchases

## Unsafe Acts

Cleaning, oiling, adjusting, moving equipment  
Feeding or supplying too rapidly  
Welding, repairing of tanks, containers, etc.,  
without supervisory clearance



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Jumping from elevations	Unnecessary exposure to moving materials or equipment
Operating vehicle at unsafe speed	Starting, stopping, moving, without warning
Working on live equipment	Driving error
Running	Horseplay
Failure to use personal protective equipment provided	Unsafe mixing of materials
Throwing material instead of passing it	Use of materials or equipment in manner not intended
Wearing unsafe personal attire	Unsafe placement of vehicles or equipment
Entering hazardous confined space without supervisory clearance	Overloading (vehicles, scaffolds, etc.)
Failure to lock, block, or secure against unexpected motion, flow of electrical current, etc.	Unsafe placement of materials
Riding in unsafe position	Gripping objects insecurely
Failure to shut off equipment not in use	Using unsafe equipment
Exposure to suspended or swinging load	Using hands instead of hand tools
Failure to place warning signs, tags, etc.	Inattention to surroundings
	Unclassified inadequate data
	Other (specify)

The investigator should keep all notes of the investigation for future reference. Other concerned people such as the work place committee and management can then review the report. They will ensure that all causes and contributing factors were identified and appropriate corrective actions were carried out.

A written report is required if an investigation reveals that a hazardous occurrence caused:

- a disabling injury;
- electric shock, or a toxic or oxygen deficient atmosphere that caused loss of consciousness;
- need for rescue, revival or other emergency procedures;
- a fire or explosion.

In any of these cases, the employer must report the result of the investigation in writing to the work place committee or representative without delay. A copy of the report must be sent to the health and safety officer at Human Resources and Social Development Canada (Labour Program) within 14 days of the occurrence. A copy of this report must be kept by the employer for a period of 10 years after it has been submitted to the health and safety officer or the Minister.

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## Remedial Action

Where there is danger of more hazardous occurrences of the same kind, remedial measures should be implemented and a preliminary report presented to the employer representative immediately. The final written report on a serious hazardous occurrence should be in the manager's hands as soon as possible. The chairperson of the work place committee is also notified so committee work can start at the same time to support the action of the investigator.

Reports on hazardous occurrences involving minor injuries and completed by the investigative team should be reviewed by the health and safety coordinator, the senior executive officer and by the work place committee at its next regular meeting. The committee may then recommend remedial measures to prevent a recurrence.

Once remedial measures are agreed upon, they should start right away. Any measures outstanding after the forecast completion date should be automatically referred to the senior executive officer by the manager. The senior executive officer in turn should insist on immediate corrective action or be convinced that the changes will be made as soon as possible.

## Hazardous Occurrence and Injury Record

All hazardous occurrences must be recorded, preferably in a bound book. This book provides a comprehensive overview of hazardous occurrences and work place illnesses. The health and safety coordinator and the work place committee should review this book, along with investigation reports, at all meetings. Set it up to display trends or deviations from the norm. For example, a sudden increase in eye injuries shows a need to review the eye protection program.

For maximum benefit from a hazardous occurrence investigation and reporting system, hazardous occurrences involving minor injury and property damage should also be investigated. Since the number of hazardous occurrences of this kind is 10 to 30 times greater than the number of disabling injury accidents, their investigation will greatly increase the pool of information an enterprise can draw on when developing preventive measures.

Some employers go a step further and investigate incidents that involve no injury, but show a deviation from prescribed procedures beyond the normal control limits. Since there is no physical evidence of an undesirable result, it is more difficult to establish what happened, so special interviewing and investigation techniques are required.

## Hazardous Occurrence Statistics

Statistics can be a valuable by-product of a good hazardous occurrence investigation and reporting program, particularly if they include information on the causes of hazardous occurrences. However, statistics are no better than the reports they come from and can be

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misleading unless they are analyzed with care. Statistics are useful in identifying trends and unusual conditions. They also have a historical value, but they should not be regarded as a principal tool for action. No competent health and safety coordinator should have to wait for statistics to know whether the plant is in a reasonably safe condition or to recommend corrective action for an identified hazard.

To be of real value, hazardous occurrence statistics must be analyzed by company, type of work unit, plant, and major geographical location. The hazardous occurrence record should be broken down by individual plant units, such as the maintenance, packaging, and warehousing departments and the main office. Otherwise the good record of a department with many employees will mask the poor record of a department with few employees. Employers with several operating locations should provide statistics for each location. These statistics and the reports of serious hazardous occurrences should be regular items on the agenda of the monthly management meeting.

The kinds of statistics produced will depend on many factors, particularly the availability of qualified persons to collect and analyze them. In small organizations, only disabling injuries, fatalities, minor injuries, property damage accidents and the frequency rate are usually recorded. In large organizations, a more sophisticated system can be employed.

## **Cost of Hazardous Occurrences**

Comprehensive hazardous occurrence reporting lets management know how costly hazardous occurrences are in both financial and human terms. We grossly underestimate the value of a hazardous occurrence prevention program if we ignore the fact that the cost of property damage and material loss from hazardous occurrences is equal to and often much greater than the cost of compensation for injuries. Without full and accurate accounting of these costs, it is impossible to develop an accurate cost benefit ratio for hazardous occurrence prevention programs. Perhaps because of this, many organizations regard such programs as unimportant. This is unwise. If organizations ensure these costs are not hidden in normal maintenance costs, the financial benefits of a good hazardous occurrence prevention program will be obvious.

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## Conclusion

The emphasis given in this review to the proper investigation and reporting of hazardous occurrences does not mean that other hazardous occurrence prevention activities are unimportant. In a typical year in the Canadian work place, one in thirteen of all workers are injured on the job. Effective hazardous occurrence investigation and reporting will identify the causes of those hazardous occurrences. A major effort should be made to control potential hazards that result from: an inadequate safety policy, a failure to assign responsibility for safety, insufficient or improper education and training, and other management control deficiencies that are usually brought to light by a safety audit or thorough inspection.

Many experienced health and safety officers claim that good hazardous occurrence investigation and reporting should be the number one priority in a health and safety program. Certainly it is a good starting point for a new program or for revitalizing an old one. It can be as sophisticated as the enterprise's resources permit, ideally including the investigation of incidents in which there are no injuries or property damage. Conducted in the manner recommended, the investigation and reporting system places the basic responsibility for hazardous occurrence prevention where it belongs, on line management, supervisors and the employees.



Human Resources and  
Skills Development Canada

Ressources humaines et  
Développement des compétences Canada

SCHEDULE 1 / ANNEXE 1  
(section 15.8 / article 15.8)

**HAZARDOUS OCCURRENCE  
INVESTIGATION REPORT**

**RAPPORT D'ENQUÊTE DE  
SITUATION COMPORTANT DES RISQUES**

<b>1. TYPE OF OCCURRENCE / GENRE DE SITUATION</b>  <input type="checkbox"/> Explosion <input type="checkbox"/> Loss of Consciousness Évanouissement <input type="checkbox"/> Disabling Injury Blessure invalidante <input type="checkbox"/> Emergency Procedure Mesures d'urgence <input type="checkbox"/> Other Autre _____ Specify / Préciser		<b>2. Department file no.</b> N° de dossier du ministère	
		Regional or District Office Bureau régional ou de district	
		Employer ID No. Numéro d'identification de l'employeur	
3. Employer's name and mailing address / Nom et adresse postale de l'employeur		Postal code / Code postal	
		Telephone number / Numéro de téléphone ( ) -	
Site of hazardous occurrence Lieu de la situation comportant des risques	Date and time of hazardous occurrence Date et heure de la situation comportant des risques		:
		Weather / Conditions météorologiques	
Witnesses / Témoins	Supervisor's name / Nom du surveillant		
4. Description of what happened / Description des circonstances			
Brief description and estimated cost of property damage / Description sommaire et coût estimatif des dommages matériels			
5. Injured employee's name (if applicable) / Nom de l'employé blessé (s'il y a lieu)		Age / Âge	Occupation / Profession
			Years of experience in occupation / Nombre d'années d'expérience dans la profession
Description of injury / Description de la blessure	Sex Sexe	Direct cause of injury / Cause directe de la blessure	
Was training in accident prevention given to injured employee in relation to duties performed at the time of the hazardous occurrence? L'employé blessé a-t-il reçu une formation en prévention des accidents relativement aux fonctions qu'il exerçait au moment de la situation comportant des risques? <input type="checkbox"/> Yes / Oui <input type="checkbox"/> No / Non Specify / Préciser			
6. Direct causes of hazardous occurrence / Causes directes de la situation comportant des risques			
7. Corrective measures and date employer will implement / Mesures correctives qui seront appliquées par l'employeur et date de leur mise en oeuvre			
Reasons for not taking corrective measures / Raisons pour lesquelles aucune mesure corrective n'a été prise			
Supplementary preventive measures / Autres mesures de prévention			
8. Name of person investigating / Nom de la personne faisant l'enquête		Signature	Date
Title / Titre		Telephone Number / Numéro de téléphone ( ) -	
9. Work place committee's or health and safety representative's comments / Observations du comité local ou du représentant			
Work place committee member's or health and safety representative's name Nom du membre du comité local ou du représentant		Signature	Date
Title / Titre		Telephone Number / Numéro de téléphone ( ) -	

10. COPIES 1 and 2 to Health and Safety Officer, COPY 3 to the Work Place Committee or Health and Safety Representative 4 to the Employer  
COPIES 1 et 2 pour l'agent de santé et de sécurité 3 pour le comité local ou pour le représentant, COPIE 4 pour l'employeur

## INSTRUCTIONS TO EMPLOYER ON THE COMPLETION OF THE HAZARDOUS OCCURRENCE INVESTIGATION REPORT

### 1. Type of Occurrence

Part II of the Canada Labour Code stipulates in subsection 125(c) that every employer has to investigate all hazardous occurrences. Part XV of the Canada Occupational Health and Safety Regulations (COHSR) defines which hazardous occurrences they must report by telephone or telex (s. 15.5) or written report (s. 15.8).

### 2. Administrative Data

These boxes are reserved for Labour Program use only.

### 3. Basic Information

Give all information required, including weather if appropriate.

### 4. Description of What Happened

The description should be as precise as possible. It should answer the basic questions "who?, what?, when?, where? and why?" and give an accurate picture of the events leading up to the hazardous occurrence. It should attempt to objectively determine, without trying to blame anyone, each of the factors involved in the hazardous occurrence.

### 5. Information About the Injured Employee

This section provides information about the injured employee and the nature of the injury.

The investigation should pinpoint the distinction between the direct cause of the injury and the direct causes of the hazardous occurrence (covered by the following section). Take, for example, the case of an eye injury caused by a flying piece of metal: The injury happened because the piece of metal flew into the employee's eye. However, the occurrence as such, that is, the fact that a piece of metal flew out, came about as a result of various other factors which together produced the hazardous occurrence. The direct cause of the injury and the direct causes of the hazardous occurrence are not necessarily the same.

Finally, it is important to determine whether the injured employee had received any training on performing his duties safely, and if not, why not?

### 6. Direct Causes of Hazardous Occurrence

This section should indicate all factors identified in the investigation as being direct causes of the hazardous occurrence. A thorough investigation will demonstrate that:

- 1) Hazardous occurrences never occur as a result of one factor only, but of several;
- 2) These factors are closely linked; and
- 3) These factors generally originate outside the employee himself, and stem instead mainly from the work environment, the equipment, the organization or the task.

### 7. Corrective Measures and Date Employer Will Implement

Corrective measures will be effective if they prevent a hazardous occurrence from recurring, that is, if they eliminate each of its direct causes. This demonstrates the importance of conducting a conclusive investigation that will obtain an accurate description of the hazardous occurrence and reveal a precise knowledge of its causes. Furthermore, it is essential to know the date the corrective measures will become effective and equally important to know why the employer has decided not to take any corrective measures, contrary to the requirements of Part II of the Code and paragraph 15.4(1)(c) of the COHSR.

Finally, the employer can also take additional measures as part of a more general accident prevention program.

### 8. Information About the Investigation

The person making the investigation prints his name and title, then signs the form. He must also give the date of the investigation to show whether it was carried out (and the report sent) by the fourteen days' deadline indicated in subsection 15.8(2) of the COHSR.

### 9. Health and Safety Committee's or Representative's Comments

The work place committee or health and safety representative, who participates in the investigation by virtue of the authority vested in him under paragraph(s) 135(7)(e) or, 136(5)(g) of Part II, records his comments on the hazardous occurrence, investigation, corrective measures or other related facts if appropriate. He then signs and dates the report.

### 10. Circulation of the Report

The employer sends copies 1 and 2 of the report to the health and safety officer of the district in which the work place is located within fourteen days of the hazardous occurrence, sends copy 3 to the work place committee or health and safety representative, and keeps copy 4.

## INSTRUCTIONS À L'EMPLOYEUR SUR LE RAPPORT D'ENQUÊTE DE SITUATION COMPORTANT DES RISQUES

### 1. Genre de situation

La Partie II du Code canadien du travail stipule au paragraphe 125 (c) que l'employeur doit faire enquête sur toutes les situations comportant des risques. La Partie XV du Règlement du Canada sur la santé et la sécurité au travail (RCSST) définit dans quelles situations l'employeur doit présenter un rapport par téléphone ou télex (art. 15.5) et par écrit (art. 15.8).

### 2. Données administratives

Ces cases sont réservées à l'usage exclusif du Programme du travail.

### 3. Renseignements de base

Consigner tous les renseignements demandés, y compris, s'il y a lieu, les conditions météorologiques.

### 4. Description des circonstances

Cette description sera la plus exacte possible. Elle permettra de répondre aux questions de base «qui?, quoi?, quand?, où? et comment?» et donnera un portrait fidèle des événements qui ont conduit à la situation. Enfin, elle visera à identifier objectivement, sans chercher à trouver un «coupable», chacun des facteurs qui ont joué un rôle dans le déroulement de la situation comportant des risques.

### 5. Renseignements sur l'employé blessé

Ces données renseignent sur l'employé blessé et la nature de la blessure.

L'enquête doit faire ressortir la distinction entre la cause directe de la blessure et les causes directes de la situation comportant des risques (demandées à la section suivante). Prenons, par exemple, le cas d'une blessure à un oeil provoquée par la projection d'un éclat de métal : la blessure est causée par l'éclat de métal qui est projeté dans l'oeil. Cependant, la situation elle-même, c'est-à-dire le fait qu'un éclat de métal soit projeté, découle d'un ensemble d'autres facteurs qui, s'ils sont réunis, vont quand même donner lieu à une situation comportant des risques. La cause directe de la blessure et les causes directes de la situation comportant des risques ne sont donc pas nécessairement les mêmes. Enfin, il est important de savoir si l'employé blessé avait reçu une formation sur l'exécution sécuritaire de ses fonctions ou, sinon, pourquoi?

### 6. Causes directes de la situation comportant des risques

On retrouvera ici tous les facteurs que l'enquête a identifiés comme des causes directes de la situation comportant des risques. Une bonne enquête fera ressortir que :

- 1) les situations comportant des risques ne découlent jamais d'un seul facteur, mais de plusieurs,
- 2) ces facteurs sont étroitement liés, et
- 3) ces facteurs sont en grande partie extérieurs à l'employé lui-même et tiennent plutôt au milieu de travail, à l'équipement, à l'organisation ou à la tâche.

### 7. Mesures correctives et date de leur mise en oeuvre

Les mesures correctives seront efficaces si elles permettent d'éviter qu'une situation comportant des risques ne se reproduise, c'est-à-dire d'en éliminer toutes les causes directes. D'où l'importance de procéder à l'enquête de sorte à obtenir une description fidèle de la situation et une connaissance exacte des causes directes de cette situation. Par ailleurs, il est essentiel, d'une part, de connaître la date d'entrée en vigueur des mesures correctives et, d'autre part, de savoir pourquoi aucune mesure n'est prise, contrairement aux exigences de la Partie II et de l'alinéa 15.4(1)(c) du RCSST.

Enfin, l'employeur peut aussi adopter des mesures supplémentaires s'inscrivant dans un programme plus général de prévention des accidents.

### 8. Renseignements sur l'enquête

La personne qui a procédé à l'enquête inscrit son nom et son titre en lettres moulées, puis elle signe le formulaire. Elle doit également inscrire la date de l'enquête, ce qui permettra au Ministère de savoir si elle a mené l'enquête (et envoyé le rapport) dans le délai de quatorze jours prescrit par le paragraphe 15.8(2) du RCSST.

### 9. Observations du comité de santé et de sécurité ou du représentant

Le comité local ou le représentant, qui participe à l'enquête en vertu des pouvoirs que lui confère le paragraphe 135(7)(e) ou, 136(5)(g) de la Partie II, consigne s'il y a lieu ses observations sur la situation, l'enquête, les mesures correctives ou d'autres faits connexes. Puis, il signe et date le rapport.

### 10. Diffusion du rapport

L'employeur envoie, dans les quatorze jours suivant la situation comportant des risques, les copies 1 et 2 du rapport à un agent de santé et de sécurité du district où se trouve le lieu de travail, il remet la copie 3 au comité local ou au représentant du lieu de travail et il garde la copie 4.