Section 10

Investigations

GYPSUM DRYWALL (SOUTHERN) LTD.

Investigation Policy

1. Objectives:
   To investigate incidents and accidents so that causes can be determined and corrective actions can be implemented to prevent reoccurrence.

2. Policy:
   All of the following will be reported and investigated:
   - Accidents that result in injuries requiring medical aid
   - Accidents that result in lost time
   - All Near Miss incident
   - And, all accidents that by regulation, must be reported OH&S, WCB or other regulatory body regardless of jurisdiction

3. Responsibilities:
   - All employees shall report all incidents to their immediate supervisor
   - Supervisors shall conduct all initial investigations and submit reports to the Safety Officer promptly (not to exceed 24hrs)
   - The Safety Officer shall determine the need for and, if necessary, direct detailed investigation. They shall also determine the cause, recommend corrective action, and report to the Management if necessary
   - The Safety Officer shall review all reports, determine corrective action to be taken, and ensure that such action is implemented

GYPSUM DRYWALL (SOUTHERN) LTD.

Reporting of Accidents and Serious Injuries

Required by OH & S

All Gypsum Drywall (Southern) employees will ensure that the reporting of accident and injuries as described below is done in accordance with the following OH&S guidelines WITHOUT EXCEPTION:

(1) *If an injury or accident described in subsection (2) occurs at a work site, the prime contractor or, if there is no prime contractor, the contractor or employer responsible for that work site shall notify a Director of Inspection of the time, place and nature of the injury or accident as soon as possible.*

(2) *The injuries and accidents to be reported under subsection (1) are*

1. *An injury or accident that results in death,*
2. *An injury or accident that results in a worker's being admitted to a hospital for more than 2 days,*
3. *An unplanned or uncontrolled explosion, fire or flood that causes a serious injury or that has the potential of causing a serious injury,*
4. *The collapse or upset of a crane, derrick or hoist, or*
5. *The collapse or failure of any component of a building or structure necessary for the structural integrity of the building or structure.*

(3) *If an injury or accident referred to in subsection (2) occurs at a work site or if any other serious injury or any other accident that has the potential of causing serious injury to a person occurs at a work site, the prime contractor or, if there is no prime contractor, the contractor or employer responsible for that work site shall*

1. *Carry out an investigation into the circumstances surrounding the serious injury or accident,*
2. *Prepare a report outlining the circumstances of the serious injury or accident and the corrective action, if any, undertaken to prevent a recurrence of the serious injury or accident, and*
3. *Ensure that a copy of the report is readily available for inspection by an officer.*

(4) *The prime contractor, contractor or employer who prepared the report referred to in subsection (3) shall retain the report for 2 years after the serious injury or accident.*

(5) *A report prepared under this section is not admissible as evidence for any purpose in a trial arising out of the serious injury or accident, an investigation or public inquiry under the Fatality Inquiries Act or any other action as defined in the Alberta Evidence Act except in a prosecution for perjury or for the giving of contradictory evidence.*

(6) *Except as otherwise directed by a Director of Inspection, an occupational health and safety officer or a peace officer, a person shall not disturb the scene of an accident reported under subsection (1) except insofar as is necessary in*

(a) *Attending to persons injured or killed,*
(b) *Preventing further injuries, and*
(c) *Protecting property that is endangered as a result of the accident.*

Any questions or concerned regarding this policy should be directed to the company Safety Officer

Report within 72 hours

1. As per provincial legislation, you have an obligation by law to report the *EMPLOYERS REPROT FO INJURY OR OCCUPATIONAL DISEASE* after receiving notice or knowledge of an injury or illness that disables or will likely disable a worker beyond the date of the accident.

2. You have 72 hours to complete and submit the Employer's Report of Injury or Occupational Disease form

3. You should submit a report to WCB-Alberta if the accident results in, or is likely to result in:

   - lost time or the need to temporarily or permanently modify work beyond the date of accident
   - death or permanent disability (amputation, hearing loss, etc.)
   - a disabling or potentially disabling condition caused by occupational exposure or activity (poisoning, infection, respiratory disease, dermatitis, etc.)
   - the need for medical treatment beyond first aid (assessment by physician, physiotherapy, chiropractic, etc.)
   - incurring medical aid expenses (dental treatment, eyeglass repair or replacement, prescription medications, etc.)

4. A copy of the form with instructions can be found at :
   http://www.wcb.ab.ca/pdfs/employers/c040_instn.pdf

5. A blank form is attached

WCB Workers' Compensation Board Alberta

P.O. BOX 2415
EDMONTON AB T5J 2S5

Phone 780-498-3999 (in Edmonton)
1-866-922-9221 (toll free in Alberta)
1-800-661-9608 (outside Alberta)

Fax 780-427-5863 or 1-800-661-1993

September 2014

EMPLOYER REPORT of Injury

C040

Seven Digit Claim # (if available):

Claim Type

1 ☐ Time Lost ☐ Modified Work ☐ Fatality
Complete entire report if claim type is one of the above

☐ No Time Lost (Notice of non-disabling injury/illness)
Complete first page only

Worker Details

Last Name: First Name: Initial:

Mailing Address: Apt# _____ ,

Social Insurance #:

City: Province: Postal Code:

Personal Health #: –

Phone Number:

Date of Birth: (Year / Month / Day) Gender: ☐ M ☐ F

Occupation: Job description: Date hired: (Year / Month / Day)

Does the worker have WCB personal coverage with this business? ☐ Yes ☐ No Is the worker a partner or director in this business? ☐ Yes ☐ No

Is the worker an apprentice? ☐ Yes ☐ No If yes, date the worker would have obtained journeyman status: (Year / Month / Day)

Employer Details

Business Name or Government Department:

WCB Account Number: Industry:

2 Employer/Supervisor Contact Name and Title:

Mailing Address:

City:

Province: Postal Code:

Contact Phone:

Phone: Fax:

Contact E-mail:

Accident Details

3 Date/time of accident: (Year / Month / Day) Time: ____ : ____ ☐ a.m. ☐ p.m.

Date/time scheduled shift started: (Year / Month / Day) Time: ____ : ____ ☐ a.m. ☐ p.m.

Date/time scheduled shift ended: (Year / Month / Day) Time: ____ : ____ ☐ a.m. ☐ p.m.

or ☐ the injury/condition developed over time

4 Date accident/injury reported to employer: (Year / Month / Day)

To whom was the accident/injury reported?: Phone Number:

5 Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what the worker was doing, including details about any tools, equipment, materials, etc., the worker was using. State any gas, chemicals or extreme temperatures worker may have been exposed to:

If you have more information, please attach a letter.

Motor vehicle accident? ☐ Yes ☐ No Cardiac condition/injury? ☐ Yes ☐ No

Letter attached? ☐ Yes ☐ No

Did the accident/injury occur on employer's premises? ☐ Yes ☐ No

6 Location where the accident happened (address, general location or site):

Were the worker's actions at the time of injury for the purpose of your business? ☐ Yes ☐ No

Were the actions part of the worker's regular duties? ☐ Yes ☐ No

Injury Details

What part of body was injured? (hand, eye, back, lungs, etc.) ☐ Left side ☐ Right side

What type of injury is this? (sprain, strain, bruise, etc.)

Employer's Signature: Date: (Year / Month / Day)

If you have any other information that would help us make a decision, or if you have concerns, please attach a letter.

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH A DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW OR APPEAL.

C 0 4 0

Worker's Last Name: | Worker's First Name: | Initial:

Social Insurance #: | Date of Birth: (Year / Month / Day)

7 Return to Work Details

a. Will/did you pay the worker regular pay while off work? ☐ Yes ☐ No Has the worker returned to work? ☐ Yes ☐ No

b. Date and time worker first missed work: (Year / Month / Day) Time: __ __ : __ __ ☐ a.m. ☐ p.m.

c. If the worker has returned to work, indicate date: (Year / Month / Day) Time: __ __ : __ __ ☐ a.m. ☐ p.m.

Current work status: ☐ Regular work duties, *or* ☐ Modified work duties ☐ Regular hours of work, *or* ☐ Modified hours of work: _____ hrs per _____

☐ Pre-accident rate of pay, *or* ☐ Revised rate of pay: $ _____ per _____

If the worker is working modified duties, please describe:

d. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? ☐ Yes ☐ No ☐ Was offered but the worker declined

e. Approximate return to work date: (Year / Month / Day) Does the worker have more than one position at your company? ☐ Yes ☐ No

8 Employment Type Details (Complete A or B or C. Select the worker's type of employment.)

A ☐ Permanent position employed 12 months of the year: ☐ Full Time ☐ Part Time ☐ Irregular/Casual

or **B** ☐ Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs): ☐ Seasonal worker ☐ Summer Student ☐ Temporary

Position start date: (Year / Month / Day) Position end date: (Year / Month / Day) ☐ Estimated ☐ Actual

How many months or days per year do you employ workers in this position?

or **C** Alternate employment: ☐ Sub contractor ☐ Piece work ☐ Vehicle owner/operator ☐ Welder owner/operator

☐ Self-employed ☐ Volunteer ☐ Commission ☐ Other

Does the worker incur expenses to perform the work (substantial materials, heavy equipment, larger tools, etc.)? ☐ Yes ☐ No

Will the worker receive a T4? ☐ Yes ☐ No

9 Earnings Details

Earnings information contact name (please print):

Earnings contact phone number: Earnings contact e-mail:

Choose A or B:

A Gross earnings for the period of one year prior to the date of injury or date the worker was hired if less than one year: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

Was any time missed from work **without pay** during the above period, excluding vacation? (eg. maternity, sick, WCB benefits) ☐ Yes ☐ No

Dates and reasons:

or **B** Worker's hourly rate of pay at time of accident: $ _____

Additional taxable benefits:

Vacation Pay ☐ Taken as time off with pay OR ☐ Paid on a regular basis % _____

Shift Premium Gross earnings: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

Overtime Gross earnings: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

Other Gross earnings: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

10 Hours of Work Details

a. Number of hours (not including overtime): _____ per ☐ Day ☐ Week ☐ Shift cycle ☐ Other: _____

b. Does the work schedule repeat?

☐ No → Average regular hours worked per week (not including overtime): _____

☐ Yes → Date shift cycle commenced: (Year / Month / Day)

Mark hours worked for one complete work schedule (use zero for days off):

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day:							
Hours per day:							
Hours per day:							

IMPORTANT Circle day of injury. See instructions

or if your schedule is more than 21 days, attach a copy of the schedule.

GYPSUM DRYWALL (SOUTHERN) LTD

NEAR MISS REPORT

Date of Incident: _____ Time: ____ : ____ AM PM

Date Incident was Reported: _____ Time: ____ : ____ AM PM

Please check all that apply: ❑ Unsafe Act ❑Unsafe Condition ❑Hazard ID

Description of the Incident:

_____

_____

_____

Location of the Incident: _____

Causes (direct and indirect):

_____ _____

_____ _____

_____ _____

_____ _____

Corrective Action(s):

_____

_____

_____

_____

_____

Target Date for completion: _____

Person Responsible: _____

Initial Upon Completion: _____

Employee Name: _____ Date: _____

Employee Signature: _____

Investigator Name: _____ Date: _____

Investigator Signature: _____

Manager/Supervisor Name: _____ Date: _____

Manager/Supervisor Signature: _____

ACCIDENT / INCIDENT REPORT (shaded areas completed by CSO)

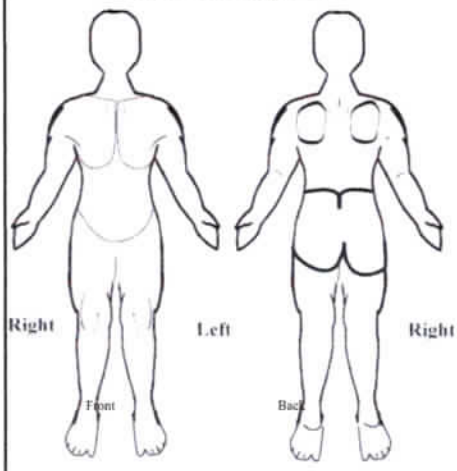
Initial Incident Information	**Incident Number (Site Name/ # of report)**
Incident: ☐ Injury/Illness ☐ Property Damage ☐ Fatality ☐ Fire ☐ Spill ☐ Collision (Roadway) ☐ Near Miss ☐ other/describe:	
Incident Date (MM/DD/YYYY)	Time (24 Hour Clock)
Site/Project	Specific Location at Site/Project
Employee Information	
Name of Employee	Name of Treatment Facility
Address of Employee	Address of Treatment Facility
Telephone #	Phone # of Treatment Facility
Date of Birth (MM/DD/YYYY)	Date Reported (MM/DD/YYYY)
Date of Hire (MM/DD/YYYY)	Time Reported (24 Hour Clock)
Employee Occupation	Incident Reported To: Name: Occupation:
Loss and Incident Classification	
☐ First Aid ☐ Medical Aid ☐ Modified Work ☐ Lost Time ☐ Fatal	
Loss	**Incident Type**

GYPSUM DRYWALL (SOUTHERN) LTD

ACCIDENT / INCIDENT REPORT (shaded areas completed by CSO)

Harm (People)	**Damage (Property)**	
☐ minor ☐ serious ☐ major ☐ fatal ☐ n/a	☐ minor ☐ serious ☐ major ☐ catastrophic ☐ n/a	☐ struck against ☐ struck by ☐ fall to lower level ☐ fall on same level ☐ caught in ☐ caught on ☐ caught between ☐ contact with harmful energy ☐ contact with harmful substance ☐ overstress ☐ over exertion ☐ overload

Indicate area of injury below



Specify right or left

Brief description of injury:

Property Damage Information

Description of Property

Description of Damage

Estimated Loss/Damage Cost

Other Actual/Potential Loss Information

Type

Description

Estimated Costs

GYPSUM DRYWALL (SOUTHERN) LTD

ACCIDENT / INCIDENT REPORT (shaded areas completed by CSO)

Evaluation of Risk Potential if Not Corrected

Severity:
☐ 1. Imminent Danger ☐ 2. Serious ☐ 3. Minor ☐ 4. Not Applicable (N\A)

Probability:
☐ A. Probable ☐ B. Reasonably Probable ☐ C. Remote ☐ D. Extremely Remote

Witness(es)

Name:
Occupation:
Statement Attached? ☐ Yes ☐ No

Name:
Occupation:
Statement Attached? ☐ Yes ☐ No

Name:
Occupation:
Statement Attached? ☐ Yes ☐ No

Name:
Occupation:
Statement Attached? ☐ Yes ☐ No

Name:
Occupation:
Statement Attached? ☐ Yes ☐ No

Name:
Occupation:
Statement Attached? ☐ Yes ☐ No

Incident Details

GYPSUM DRYWALL (SOUTHERN) LTD

ACCIDENT / INCIDENT REPORT (shaded areas completed by CSO)

Diagram of Scene

Photographs attached ☐ Yes ☐ No

Detailed Sketch attached ☐ Yes ☐ No

Causes

Direct Causes:

Basic (Indirect) Causes:

Root Causes:

GYPSUM DRYWALL (SOUTHERN) LTD

ACCIDENT / INCIDENT REPORT (shaded areas completed by CSO)

Corrective Actions

Action	Deadline	Responsibility	Date

GYPSUM DRYWALL (SOUTHERN) LTD

Procedures in the event of a vehicle accident

1. Vehicle accidents may happen through the course of a work day and will need to be dealt with. These can range from minor to major and each must be investigated or at least have the details recorded in order to ensure the integrity of the accident scene

2. First and foremost, ensure that you, any passengers and the passengers of any other vehicles have received first aid if required. If your injuries are such that you cannot assist in providing first aid ensure that you seek help for yourself.

3. ALL vehicle accidents will be reported within 24hrs. Failure to do so may result in termination.

4. Steps in the event of an accident –

    a. Administer self-aid and first aid as required
    b. Contact 911
    c. Call or text the Gypsum Safety Officer
    d. Contact the assigned insurance provider
    e. Get details from the other driver (photos of license, registration, proof of insurance)
    f. Get pictures of any damage to the vehicles involved. Try to get the pictures showing license plates, points of impact, any skid marks, tire tracks, signage or lighting, and pictures of the weather/ road conditions
    g. If possible get contact information from the driver
    h. If police are involved ensure you have copies of any statements provided

5. Minor Accidents are ones where damage to each vehicle is expected to be less than $1000.00 and no injuries are noted at the time of the accident. Ensure that all drivers and passengers are unharmed, move the vehicles off the roadway to prevent any further accidents. Ensure all persons are in a safe location away from the roadway.

6. Major accidents are ones where damage is in excess of $1000.00 to each vehicle, where any driver or passenger is injured or where more than one other vehicle is involved. Ensure all persons who can be moved to a safe location have done so, protect any injured persons from further harm as best as possible, preserve the integrity of the accident scene where possible.

7. Any criminal charges stemming from a police investigation will be the responsibility of the offending driver unless mechanical fault can be attributed as a cause of the accident.

8. Only drivers who have been authorized by Gypsum Drywall to operate a GDSL owned vehicle may act as the driver of said vehicle. No other persons may be assigned status as a driver with the sole exception of the necessity to deliver an injured person to medical aid.

ACCIDENT FLOW CHART